STATE OF MICHIGAN

IN THE SUPREME COURT

PATRICIA MERCHAND,

Plaintiff-Appellee,

v

RICHARD L. CARPENTER, M.D.,

Defendant-Appellant,

and

MID-MICHIGAN EAR, NOSE, AND THROAT, P.C., a domestic professional service corporation, jointly and severally,

Defendant.

SC No. _____
COA No. 327272
LC No. 12-1343-NH
(Ingham Circuit Court)

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**NOTICE OF FILING APPLICATION**

**APPLICATION FOR LEAVE TO APPEAL**

**PROOF OF SERVICE/STATEMENT REGARDING E-SERVICE**

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**NOTICE OF FILING APPLICATION**

TO: Michigan Court of Appeals Clerk
Via TrueFiling Electronic Filing

Clerk of the Court
Ingham County Circuit Court
313 W. Kalamazoo
P.O. Box 40771
Lansing, MI 48901-7971

NOW COMES Defendant-Appellant Richard L. Carpenter, M.D., and states that on October 25 2016, his application for leave to appeal has been filed with the Michigan Supreme Court.

Respectfully submitted,

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Dated: October 25, 2016

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## STATEMENT OF APPELLATE JURISDICTION

Defendant-Appellant Richard L. Carpenter, M.D., states that this Court has jurisdiction to consider and resolve this application pursuant to MCR 7.303(B) (the Supreme Court may review by appeal a case after decision by the Court of Appeals). This Court's jurisdiction has been timely and properly invoked, as evidenced by the following:

- August 2, 2016 Court of Appeals Opinion (Majority Opinion and Dissenting Opinion) (**Exhibits A** and **B**);
- August 23, 2016 Motion for Reconsideration (timely filed within the 21-day limit of MCR 7.215(I)(1));
- September 14, 2016 Court of Appeals Order Denying Motion for Reconsideration (**Exhibit C**); and
- October 25, 2016 Application for Leave to Appeal and accompanying documents, timely filed with this Court within the 42-day limitation of MCR 7.305(C)(2)(b).

## STATEMENT IDENTIFYING THE JUDGMENT OR ORDER APPEALED FROM

This is a medical malpractice action which was tried to a jury verdict of no cause of action in the Ingham County Circuit Court. Plaintiff-Appellee Patricia Merchand ("Plaintiff" or "Ms. Merchand") appealed by right from the April 21, 2015 Judgment of No Cause of Action (**Exhibit D**), entered by the Honorable Rosemarie E. Aquilina, who presided over the jury trial. One of the issues presented by Plaintiff was the trial court's decision to prohibit Plaintiff from introducing evidence from Dr. Carpenter's past medical malpractice cases. Plaintiff sought to admit the testimony of an expert witness, Dr. Michael Morris, who Plaintiff proffered had reviewed the medical records of other patients of Dr. Carpenter, all of whom were also plaintiffs in medical malpractice cases brought against him. Dr. Morris opined that Dr. Carpenter's post-surgical recordkeeping in this case was incomplete, by reference to and comparison with his recordkeeping for other patients, each of whom was a plaintiff in a past or then-pending malpractice case brought against Dr. Carpenter. The trial court exercised its discretion under MRE 403, determined that any probative value of Dr. Morris' testimony was substantially outweighed by the danger of unfair prejudice and confusion, and excluded the testimony. The jury found Dr. Carpenter was not professionally negligent.

In a split decision, the Michigan Court of Appeals disagreed, found the trial court had abused its discretion by excluding the testimony, and reversed and remanded for a new trial. The Majority (Judges Owens and Borrello) reasoned that this other acts evidence demonstrated that Dr. Carpenter had a scheme or plan when it came to "charting that minimized his exposure to liability by not recording patients' post-operative complaints." (**Exhibit A**, Majority Opinion, p 6 (Owens, P.J., and Borrello, J) (hereinafter "Majority Opinion")). However, the Majority did not identify the potential prejudice to Dr. Carpenter if the other acts evidence was admitted, and

necessarily erred by failing to consider the prejudice side of the requisite MRE 403 balancing. In a comprehensive opinion, the Dissent (Judge O'Brien) found that this other acts evidence was irrelevant because the asserted breach of the standard of care was negligent surgery causing a medical consequence (not negligent recordkeeping), and because Dr. Morris' testimony failed to establish a system, plan, or scheme in recordkeeping (the lever used by the Majority to assign probative value to the testimony). The Dissent further found that admission of Dr. Morris' opinions would create unfair prejudice for various reasons, including both parties' attempts to prove or disprove these other medical malpractice allegations, which had no bearing on the issue of whether Dr. Carpenter was surgically negligent in this case (**Exhibit B**, Dissenting Opinion, O'Brien, J. pp 3-8) ("Dissenting Opinion").

On cross appeal, Dr. Carpenter argued *inter alia* that the trial court erred in instructing the jury on the doctrine of res ipsa loquitur. The Majority disagreed, reasoning that the type of injury here—nerve injury—does not happen in the absence of negligence, relying on *Wilson v Stilwill*, 411 Mich 587, 608, 610; 309 NW2d 898 (1981) (**Exhibit A**, pp 8-9). The Dissent found otherwise, reasoning that this type of injury could occur without any negligence on the part of the treating physician because the plaintiff and defense experts testified that nerve injury is a known complication of the subject procedure and could occur without any negligence on behalf of the treating physician (**Exhibit B**, p 10).

In an order dated September 14, 2016, Judges Owens and Borrello denied Dr. Carpenter's motion for reconsideration, with Judge O'Brien indicating she would grant the motion for reconsideration (**Exhibit C**).

Dr. Carpenter requests the following relief:

- Reverse the Majority Opinion and adopt the Dissenting Opinion (in which case remand is unnecessary because the

Dissenting Opinion rejected Plaintiff's alternative arguments for new trial, and because review of the res ipsa loquitur issue is mooted if there is no new trial);

- Alternatively, reverse the Majority Opinion, and remand to the Court of Appeals for consideration of the issues left unaddressed by the Majority Opinion; and

- In the second alternative, reverse the Majority Opinion with respect to the res ipsa loquitur argument, only, for purposes of proceedings on remand.

As explained in greater detail in the section entitled "The Need for Supreme Court Review," the grant of leave to appeal is essential to address and memorialize the proper application of both the probative and prejudice sides of the requisite MRE 403 balancing; the correct degree of deference for an abuse of discretion standard reviewing decisions under MRE 403; the danger and impropriety of the admission of propensity evidence arising from reference to past or existing medical malpractice cases against the health care provider; and the erroneous notion that all character evidence is automatically admissible.

## STATEMENT OF THE QUESTIONS PRESENTED

I.

WHETHER THE COURT OF APPEALS MAJORITY OPINION ERRED BY DETERMINING THAT THE TRIAL COURT ABUSED ITS DISCRETION BY FINDING IRRELEVANT, AND ALTERNATIVELY FINDING INADMISSIBLE UNDER MRE 403, PLAINTIFF'S STANDARD OF CARE EXPERT'S TESTIMONY THAT MEDICAL RECORDS FROM SEVERAL OF DR. CARPENTER'S OTHER PATIENTS (EACH OF WHOM HAD FILED LAWSUITS AGAINST DR. CARPENTER), DEMONSTRATED THAT DR. CARPENTER'S RECORDKEEPING IN THIS CASE FOLLOWED A PATTERN OF INSUFFICIENT RECORDKEEPING ESTABLISHED THROUGH THESE OTHER PATIENT-PLAINTIFFS?

Defendant-Appellant Dr. Carpenter says, "yes."

Plaintiff-Appellee says, "no."

The trial court says, "yes."

The Michigan Court of Appeals Majority says, "no."

The Michigan Court of Appeals Dissent says, "yes."

II.

WHETHER THE TRIAL COURT ERRED BY DETERMINING THAT PLAINTIFF HAD PROPERLY PLED RES IPSA LOQUITUR AND THAT IT APPLIED TO THE FACTS OF THIS CASE, UNDER WHICH RULING THE TRIAL COURT NOT ONLY ERRONEOUSLY INSTRUCTED THE JURY PURSUANT TO M CIV JI 30.05 [RES IPSA LOQUITUR], BUT ALSO REFUSED TO INSTRUCT THE JURY UNDER M CIV JI 30.04 [MEDICAL UNCERTAINTIES]?

Defendant-Appellant Dr. Carpenter says, "yes."

Plaintiff-Appellee says, "no."

The trial court says, "no."

The Michigan Court of Appeals Majority says, "no."

The Michigan Court of Appeals Dissent says, "yes."

## STATEMENT OF FACTS

### A. Introduction.

This case presents a confluence of important issues under Michigan law, including the proper amount of deference afforded a trial court's ruling that evidence is inadmissible under MRE 403 as marginally relevant and substantially outweighed by prejudice, where the trial court accurately foresees that admission of the evidence would result in a series of mini-trials as to other medical malpractice allegations against the same doctor. In this medical malpractice action, Plaintiff Patricia Merchand argued one theory of liability: Dr. Carpenter negligently injured Plaintiff's hypoglossal nerve ("HGN") during the removal of her submandibular gland in 2010. During trial, Plaintiff sought to have an expert witness testify that he had reviewed eight to ten sets of medical records involving other patients of Dr. Carpenter—who also happened to be plaintiffs in cases against Dr. Carpenter—to opine that Dr. Carpenter was not a good recordkeeper. The proffered relevance for this testimony was Plaintiff's contention that the manifested symptoms indicative of an HGN injury did not appear in Plaintiff's medical records solely because Dr. Carpenter failed to record such observations. Plaintiff did ***not*** argue that Dr. Carpenter's alleged inadequate recordkeeping played any role in Plaintiff's injury. At trial, Plaintiff did not specify the rule of evidence under which she sought to admit this testimony (subsequently asserted to be MRE 404(b) on appeal).

The trial court determined that the evidence was irrelevant because Plaintiff did not claim that Dr. Carpenter's alleged failure to adequately record surgery complications or post-operative symptoms played any role in her injury. The trial court also determined that, if there was any probative value, it was substantially outweighed by prejudice and the risk of jury confusion and thus was properly excluded under MRE 403. The trial court cited specifically to this Court's

decision in *Wischmeyer v Schanz, MD*, 449 Mich 469; 536 NW2d 760 (1995), and the well-acknowledged rule that the mere fact that a physician has been sued for malpractice is not probative of his or her truthfulness, competency, or knowledge, *Heshelman v Lombardi*, 183 Mich App 72, 85; 454 NW2d 602 (1990). The Michigan courts have consistently acknowledged the danger of unfair prejudice in the admission of propensity evidence, barred under the rationale that such evidence diverts jury's attention from the facts of the case being tried, and instead focuses such attention on the probability that the defendant, who had made so many mistakes before, made one again. *Wlosinski v Cohn*, 269 Mich App 303, 312; 713 NW2d 16 (2005).

The Majority found an abuse of discretion on the exclusion of this other acts evidence. With respect to the trial court's findings of prejudice and confusion, the Majority stated only that "[u]nfair prejudice refers to the tendency that the jury will give undue or preemptive weight to the evidence," and that fairness and accuracy demanded that the jury be provided with Dr. Morris' testimony (**Exhibit A**, p 6). Without so much as summarizing the nature of the unfair prejudice of this testimony, the Majority reversed the trial court's MRE 403 ruling, and thus necessarily erred because the MRE 403 balancing requires consideration of two sides of a scale – a probative side and a prejudicial side. Although recognizing the prohibition on reference to other medical malpractice actions filed against a defendant under *Heshelman*, but making no reference to the bar on propensity evidence under *Wlosinski*, the Majority found that the other acts evidence was relevant and thus admissible under MRE 404(b) (authority which had not been proffered by Plaintiff at the trial court level). According to the Majority, such evidence could properly be used to show that Dr. Carpenter followed a particular pattern of recordkeeping when it came to cases with serious complications resulting from surgery (apparently a pattern of inadequate recordkeeping—the Majority Opinion is not clear) (**Exhibit A**, pp 4-6).

Finally, the Majority rejected Dr. Carpenter's appellate argument that any error was harmless because it was undisputed (and Plaintiff admitted on appeal) that the gross abnormal changes in Plaintiff's tongue (deviation and fasciculations)[1]—which indicate HGN damage if present within 3-4 months of surgery—did not begin until 21 months after the surgery. Thus, claims that Dr. Carpenter failed to document Plaintiff's early complaints of less severe symptoms (tongue biting, spitting, difficulty talking and swallowing in the days and months after the surgery) were immaterial to the case.

The Dissent recognized the inconsistency between the Majority Opinion's finding that other acts evidence is generally inadmissible, and its conclusion that the other acts evidence here was so relevant and probative that the trial court abused its discretion when finding that the risk of prejudice and jury confusion substantially outweighed its probative value. The Dissent noted that the record was not clear that Plaintiff had even asserted the grounds for relevancy under MRE 404(b). The Dissent reasoned that because this was a negligent surgery case, and there was no claim that poor recordkeeping somehow resulted in Plaintiff's injury, the evidence in question was irrelevant, or marginally probative at best. The Dissenting Opinion quoted the ***entirety*** of the special record made of Dr. Morris' testimony, and opined that the opinions proffered simply had nothing to do with a system, plan, or scheme in recordkeeping, the alleged relevance under MRE 404(b). Perhaps most importantly, unlike the Majority, the Dissent first identified and then analyzed the prejudice and jury confusion that would result if testimony were admitted regarding Dr. Carpenter's recordkeeping for eight to ten other surgeries, which were themselves the subject of malpractice suits against Dr. Carpenter:

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[1] Deviation is the turning or twisting of the tongue to one side of the mouth; fasciculations are involuntary movements of the tongue, described as "writhing" or "dancing" (Tr. 3/20/15, pp 29, 30-31).

- The defense would proffer in rebuttal additional testimony regarding Dr. Carpenter's recordkeeping during "all other surgeries that did not result in malpractice allegations;"

- Foundation would have to be established to determine the accuracy of these other medical records;

- Plaintiff did not proffer evidence as to whether other patients actually made complaints to Dr. Carpenter which were not documented in their medical records; and

- It would be highly prejudicial and deny Defendant a fair trial to have both parties, through Dr. Morris' admitted testimony, then attempt to prove or disprove these other allegations and other medical malpractice actions.

(**Exhibit B**, pp 6-8).

As explained in the following pages, the Majority simply erred by finding an abuse of discretion under these standards. It altogether failed to determine the prejudice to the defense if the evidence in question was admitted. At no point in the Majority Opinion is this potential prejudice considered, in stark contrast to pages 7-8 of the Dissenting Opinion. There can be no legitimate finding of "abuse of discretion" under MRE 403 when the Majority did not perform the required balancing of probative value and prejudicial effect imbedded in MRE 403. Indeed, the Majority Opinion did not even recite the prejudice identified by the trial court, let alone determine whether it was an abuse of discretion—i.e., outside the range of principled outcomes—to find such prejudice substantially outweighed the probative value of the testimony. The remaining errors of the Majority Opinion are outlined more fully in the Argument portions of this application.

In the unlikely event the Majority Opinion survives, the trial court did misstep in finding res ipsa loquitur applies to the type of injury in this case. That argument is presented as an issue

to be resolved only if this Court determines, in the first instance, that there is a need for a new trial.

**B. Plaintiff's complaint and affidavit of merit.**

Dr. Carpenter performed surgery on Plaintiff on August 3, 2010, to remove Plaintiff's right submandibular gland (**Exhibit E**, Complaint, ¶¶ 27, 37). Plaintiff contends that during the course of surgery, Dr. Carpenter did not properly identify and inspect the anatomy and landmarks, including the hypoglossal nerve (the 12th cranial nerve which controls movements of the tongue), which he then negligently injured (*Id.* at ¶¶ 36-39). In her complaint, Plaintiff asserts professional negligence against Dr. Carpenter in Count I (*Id.* at ¶¶ 18-71(a)-(m)) and asserts that MMENT was vicariously liable, as well as directly liable for its negligence in failing to ensure that Dr. Carpenter was competent to provide proper care and treatment (*Id.* at ¶¶ 72-75).[2]

Nowhere in Plaintiff's complaint is it alleged that Dr. Carpenter's record-keeping or supposed failure to record Plaintiff's post-operative symptoms was a breach of the standard of care with respect to her care and treatment both during and after her surgery. Nor does Plaintiff's complaint make any claims of malpractice regarding Plaintiff's post-operative care and treatment.

The affidavit of merit executed by Dr. Morris likewise does not contain any assertion that poor record-keeping was a violation of the standard of care or that Plaintiff's post-operative care played any part in causing her alleged injuries (**Exhibit E**).

[2] On the first day of trial, MMENT was dismissed with prejudice via stipulation from this case (Tr. 3/16/2015, pp 5-7).

**C. Dr. Carpenter signs the affidavit of meritorious defense but is not qualified as an expert at trial, and has no personal recollection of Plaintiff's surgery.**

Dr. Carpenter signed the affidavit of meritorious defense submitted by Defendants pursuant to the statutory requirements of MCL 600.2912e. Although Dr. Carpenter was listed as a potential expert witness on Defendants' pretrial witness list, at trial, the defense did not seek to qualify Dr. Carpenter as an expert witness under MRE 702 and 703. Instead, Dr. Carpenter testified as a fact witness regarding Plaintiff's care and treatment, and did not offer any expert opinions or testimony.

At trial, Dr. Carpenter admitted that he had no personal recollection of performing Plaintiff's surgery or of her post-operative visits. Instead, he relied on his surgical notes and treatment records, along with his usual pattern and practice of performing submandibular gland removal surgeries over the past 30 years. Dr. Carpenter testified that Plaintiff's submandibular gland suffered from chronic sialadenitis, or a long-standing inflammation and infection of the salivary gland (Tr. 3/19/15, pp 54, 57). Dr. Carpenter testified that he used a harmonic scalpel to perform the dissection and removal of Plaintiff's submandibular gland, and did not encounter any complications during the 23-minute surgery (Tr. 3/17/15, pp 106-107, 186-189, 190-191). He did not locate or identify Plaintiff's hypoglossal nerve as it was not his pattern or practice to do so, given that that nerve was located beneath the mylohyoid muscle forming the inferior boundary of the surgical field (*Id*. at 111-112, 164, 193-194, 197). Dr. Carpenter removed a single stone from the gland and left a portion of the gland behind (Tr. 3/19/15, pp 52-53; Tr. 3/17/15, pp 113-114). The chronic infection and inflammation of Plaintiff's submandibular gland persisted in that area following surgery, and he treated Plaintiff with antibiotics during her post-operative course (Tr. 3/19/15, pp 57-58, 61, 63, 68).

**D. Pretrial motions in limine and related rulings at trial regarding other acts evidence.**

On December 16, 2014, Judge Aquilina heard argument on ten pretrial motions, most of which were motions in limine filed by the defense (Tr. 12/16/2014, pp 5-6). Judge Aquilina also reconsidered or revisited some of these motions just before and during trial.

**1. Motion to exclude other claims of malpractice against Dr. Carpenter.**

At the time of trial, there were several other medical malpractice cases pending against Dr. Carpenter, two or three of which involved nerve injury during surgery in the neck region (Tr. 3/23/15, p 163). Dr. Carpenter moved in limine to exclude evidence of these other malpractice claims and/or actions because they were improper character evidence, irrelevant, and if relevant, more prejudicial than probative, citing MRE 401, 402, 403, 404(b), 407, 408, and 608(b). The defense specifically argued that evidence of prior malpractice claims was irrelevant to Dr. Carpenter's credibility and thus inadmissible under MRE 608(b). As defense counsel explained, "[i]njuries in other case, whether there are poor outcomes or negligence, have no bearing on whether the care in this case was negligent" (Tr. 12/16/14, pp 34-35).

In response, Plaintiff argued that the sheer number of alleged nerve injuries in cases involving Dr. Carpenter showed a "similarity of negligence" in the instant case, and a "long pattern" of Dr. Carpenter's failure to document and diagnose the alleged nerve injuries (Tr. 12/16/14, p 20). Arguing that Dr. Carpenter would be presented as an expert witness, Plaintiff claimed the jury needed to know about these accusations in other cases involving other patients, other surgeries and other nerves because it would show the jury that "[n]othing in his records can be trusted" (*Id*. at 21). Plaintiff asserted that this Court, in *Wischmeyer*, 449 Mich at 477-480, allowed for cross examination of an expert witness regarding his prior failed back surgeries as relevant to his competency to render standard of care opinions, and that cross examination of Dr. Carpenter regarding other claimed instances of nerve injuries should therefore be allowed

because "[h]e's testifying as an expert" (*Id*. at 30). However, it is undisputed that Dr. Carpenter did not in fact testify as an expert; as defense counsel pointed out, cases like *Wischmeyer* involving prior adverse outcome attacks on the credibility and qualifications of expert witnesses do not raise the MRE 403 concerns regarding unfair prejudice that are found with similar attacks on a ***defendant***, who must necessarily answer for the care that he provided to the plaintiff, in the form of a jury's finding of negligence or no negligence (*Id*. at 25). The trial court granted Defendant's motion under MRE 403, subject to a motion for reconsideration (*Id.* at 35).

During her cross examination of Dr. Carpenter under the adverse witness statute, Plaintiff counsel attempted to introduce evidence that other patients of Dr. Carpenter had complained, to his knowledge, that he did not write down their post-operative complaints of nerve problems on their follow-up visits (Tr. 3/17/15, pp 137-138). Defense counsel objected that this line of questioning was irrelevant to the actual medical claims in this case, and that attempts to impeach Dr. Carpenter with extrinsic evidence on a collateral matter were improper because Dr. Carpenter did not deny that he might not have recorded Plaintiff's post-operative complaints (*Id.* at 139-140). In response to Defendant's objection, the trial court recognized that this line of inquiry would necessarily cause the jury to have to try "cases within cases," with the potential of having the plaintiffs of the other cases come in and testify as to their complaints against Dr. Carpenter (*Id*. at 139, 143). The court also found this inquiry irrelevant to the case being proved by Plaintiff, observing "[w]e don't get that there's infection by some other person's chart. We have to stick to the evidence here" (*Id.* at 147-148). The court ruled that Plaintiff counsel would be allowed to question Dr. Carpenter regarding whether it was possible that he had mischarted or forgotten to chart something with respect to Plaintiff's symptoms (*Id.* at 143). Dr. Carpenter

admitted that his medical records for patients were "not a hundred percent accurate," and that he was sure he had mischarted some patient information on occasion (*Id*. at 151).

**2. Special record of Dr. Morris' testimony as to other acts evidence.**

Plaintiff called Dr. Michael Morris to offer standard of care opinions at trial as a board-certified otolaryngologist. The trial court permitted Plaintiff to make a special record of Dr. Morris' testimony regarding his review of the patient records and complaints in the other medical malpractice cases involving Dr. Carpenter. The entirety of Dr. Morris' testimony was as follows:

Q. Doctor Morris, have you had an occasion to become familiar with other patient care rendered by Richard Carpenter other than this case?

A. Yes.

Q. Tell me about how you've become aware of that.

A. Through the process of being asked to review and reviewing other cases that were presented to me for review who were cared for by Doctor Carpenter.

Q. Just approximately how many cases have you reviewed involving Richard Carpenter's treatment of patients?

A. Eight or ten.

Q. And have any of those involved nerve injuries?

A. Yes.

Q. Just approximately how many of those?

A. Two or three others.

Q. Okay. What type of other nerve injury cases have you had a chance to review?

A. Nerve injuries of the neck, recurrent neck injuries, marginal mandibular nerve injuries. That's all I can think of.

Q. In one of those cases did it actually involve a submandibular glad and tumor removal surgery?

A. Yes.

Q. And in respect to all the different cases that you have reviewed concerning Richard Carpenter and the separate reports and the office records, do you have any particular insight concerning his operative reports?

A. Yes.

Q. What is that, please?

A. That the operative report doesn't characterize any problem occurring during the surgery even if there's a complication that's significant.

Q. Is that information frequently left out of his operative reports?

A. Yes.

Q. How about with respect to his office records. Based on reviewing charts from, you know, many, many of his patients, do you have any observations concerning how he maintains his -- you know, his charting in his office records for patient complaints?

A. Yes.

Q. What is that, please?

A. That what the patients complain about to him isn't recorded but they may see another doctor in his practice the next day or the next week and the other doctor records that information that had to be present on the day they saw Doctor Carpenter.

Q. Okay. And have you also gained any familiarity concerning just, you know, how meticulous Richard Carpenter's dissections are during surgeries?

A. Yes.

Q. What is the information you have learned?

A. That during some of his surgeries, operation on one part of the nose led to problems in another part of the nose that wasn't even involved with the surgery, or an operation in the nose ended up causing blindness in a patient. That wasn't part of the nasal surgery. Or operations on the thyroid gland, removed the wrong side of the gland was another case.

Q. Was that what you would describe as meticulous dissection?

A. No.

Q. Is that what you would call careful attention to the details of the operation and the acts performed in the surgery?

A. No.

(Tr. 3/23/15, pp 163-165).

**E. Plaintiff's trial theory of medical negligence and testimony regarding her symptoms.**

After the trial court provided initial instructions to the jury, it explained Plaintiff's theory of the case:

> "[THE COURT] In this case plaintiff, Patricia Merchand, claims that Richard Carpenter, M.D., breached the standard of care and committed medical malpractice when he performed a submandibular gland removal procedure on plaintiff on August 3rd, 2010. Plaintiff claims she suffered damages due to an injury to her hypoglossal nerve that occurred at the time of her August 3rd, 2010, surgery."

(Tr. 3/17/2015, p 10). At trial, Plaintiff and members of her family testified that Plaintiff experienced tongue biting, difficulty swallowing and chewing, impaired speech and spitting when talking in the days and months following her surgery (Tr. 3/19/15, pp 137-138, 147-149, 184-185; Tr. 3/20/15, pp 118, 120-123, 125, 128, 142). Plaintiff testified that she told Dr. Carpenter and others at MMENT about her post-surgical complaints of a swollen tongue, tongue biting, and difficulty swallowing, but that no one ever documented these complaints in her charts (Tr. 3/17/15, p 116; Tr. 3/19/15, pp 116-128). Plaintiff continued to see Dr. Carpenter for post-operative visits until March 2011. Plaintiff testified that, at each visit, Dr. Carpenter would tell her that her wound was "healing nicely," and that her complaints were merely part of the normal healing process (Tr. 3/17/15, pp 126-127; Tr. 3/20/15, pp 131-136). Plaintiff's surgical incision initially swelled and was painful, and eventually opened up and leaked fluid (Tr. 3/17/15, pp 124-125; Tr. 3/19/15, pp 58-59). Dr. Carpenter drained the fluid from the wound, cauterized it, and gave Plaintiff a variety of antibiotics to treat what he perceived to be an ongoing infection, present before the gland was removed (Tr. 3/19/15, pp 56-58). Dr. Carpenter acknowledged that his records did not explicitly document an ongoing infection, but surmised that Plaintiff had an

ongoing infection due to the fact that he continued to prescribe an antibiotic (*Id.*). In his experience, this was not an unusual post-surgical complication (*Id.*).

At trial, Plaintiff pointed to her medical records from other various treaters to support her contention that she had been experiencing tongue biting and excess saliva production since the time of surgery, namely a record from her primary care doctor, Dr. McLaughlin, in January 2011. However, it is undisputed (and Plaintiff admits on appeal), that the gross abnormal changes in her tongue (deviation and fasciculations) did not begin until April 2012, 21 months after her surgery (Tr. 3/20/15, pp 141-142; Tr. 3/24/15, p 234; Tr. 3/26/15, p 16; Tr. 2/26/15, p 16). At her appointment in May 2012, Dr. McLaughlin observed the deviation and fasciculations on the right side of Plaintiff's tongue, which she had not observed during her routine check of Plaintiff's mouth and tongue in her annual exam in April 2011 (Tr. 3/24/15, pp 232, 234; Tr. 2/26/15, pp 14, 35).

Dr. McLaughlin referred Plaintiff to Dr. Shannon Radgens, an ENT, for further treatment of her tongue condition. Dr. Radgens testified that Plaintiff's reported symptoms after the surgery were difficulty swallowing, and pain, biting and swelling of the tongue (Tr. 2/27/15, p 10). Her "tongue issue," i.e., deviation and fasciculations, reportedly began in April 2012 (*Id.* at 11). After seeing the notes from this visit, Plaintiff wrote to Dr. Radgens to correct certain information in her chart, specifying that at that time (June 5, 2012) she was ***not*** having difficulty swallowing, and that she did not bite her tongue "constantly" (*Id.* at 18).

Plaintiff subsequently saw ENT Dr. Jeffrey Stanley on July 26, 2012, at which time he confirmed the denervation of Plaintiff's tongue on the right side. Plaintiff told Dr. Stanley that the visible changes to her tongue (fasciculations and deviation) had not started until April 2012

(Tr. 3/9/15, pp 6-8). At the time of his trial testimony, Dr. Stanley observed that Plaintiff's fasciculations had gotten milder since he first saw her (*Id.* at 18).

Plaintiff also saw neurologist Dr. Andrea Almeida, who was qualified at trial as an expert in neurology and opined that Plaintiff's symptoms were caused by an injury to her hypoglossal nerve during her surgery. In her opinion, Plaintiff's progression of symptoms (tongue biting, difficulty with speech, pain, and excess saliva immediately after surgery, progressing to tongue atrophy, weakness and fasciculations over the course of two years), was consistent with a hypoglossal nerve injury during the August 2010 surgery (Tr. 3/4/15, pp 7-8, 24).

**F. The expert witnesses' opinions.**

As with most medical malpractice trials, there was conflicting expert witness opinions heard and considered by the jury. In addition to the expert opinions proffered by Drs. Stanley and Radgens as to otolaryngology and Dr. Almeida as to neurology, Plaintiff relied upon the opinion testimony of Dr. Michael Morris, board certified in otolaryngology (Tr. 3/23/2015, pp 23-28). Dr. Morris explained in detail how a harmonic scalpel can injure the surrounding tissue if not used correctly during surgery (*Id.* at 53-56). He opined that Plaintiff exhibited "classic" symptoms of damage to the hypoglossal nerve after surgery (*Id.* at 61-62). While admitting that he did not know "exactly what Dr. Carpenter did during the course of the dissection" (*Id.* at 135), Dr. Morris testified that one hundred percent of the time, "without exception," when there is an injury to the hypoglossal nerve during a submandibular gland excision surgery, the injury is a result of the physician breaching the standard of care (*Id.* at 37; see also pp 59-61). Dr. Morris admitted that injury to the hypoglossal nerve is a recognized complication of this procedure (*Id.* at 125-126). Even so, Dr. Morris' methodology of finding a breach of the standard of care was that the consequence of the surgery—injury to the hypoglossal nerve—told him what happened

during the surgery (*Id.* at 135). Dr. Morris ruled out infection, "stretch injury," and scars and adhesions as potential causes of Plaintiff's nerve damage (*Id*. at 90-91, 95).

Plaintiff also called board-certified neurologist and clinical neurophysiologist Dr. Steven Schechter as an expert witness. Dr. Schechter testified to a reasonable degree of medical certainty that Plaintiff's nerve injury was caused by something which occurred during Plaintiff's surgery, based on the absence of symptoms prior to the surgery, and the progression of symptoms following the surgery (Tr. 3/20/15, pp 19-20, 27, 32-33, 70-71, 74). Dr. Schechter opined that a hypoglossal nerve injury occurring during surgery would ***not*** result in immediate, total paralysis of the tongue, but rather that deficits in motor function would take months and years to develop (*Id*. at 29, 36-37, 52). In his opinion, the time course of Plaintiff's symptoms, as reflected in the medical records, was typical for an injury to the right hypoglossal nerve occurring at the time of surgery (*Id.* at 28-31, 62).

The defense called as expert witnesses Dr. Eugene Rontal, M.D. and Dr. Harry Borovik, M.D., each board certified in otolaryngology. Dr. Rontal explained that, during the course of the surgery, not everything can be seen, and that nerve injury is an acknowledged potential risk and complication of this procedure (Tr. 3/24/2015, pp 146-147). Dr. Rontal opined there was no evidence that anything was done wrong in the operating room, noting that Plaintiff did not have symptomology with respect to the injury to this motor nerve until 21 months following the surgery, and that if there had been a hypoglossal nerve cut, Plaintiff would have been immediately feeling the effects and asking why her tongue could not move (*Id.* at 164-165). Specifically, if there had been injury to the nerve during the surgery, the deviation would have happened immediately and been obvious, and the fasciculations would have developed within 3 to 4 months of the injury (*Id*. at 161-162, 164-165, 167, 170, 174). Notably, Plaintiff denied that

she had any visible deviation of the tongue when she saw Dr. McLaughlin in May 2011, 9 months after surgery (*Id.* at 232). She also denied that the changes to her tongue had been "cataclysmic" (*Id.* at 229).

Dr. Borovik explained to the jury the particulars of the surgery (*Id.* at 27-29), opined that Dr. Carpenter did not injure the hypoglossal nerve (*Id.* at 50), and, like Dr. Rontal, reasoned that if there was an intraoperative injury to this motor nerve, there would have been an immediate loss of motor function, which did not occur in this case (*Id*. at 61-67). Dr. Borovik confirmed that nerve injury is a recognized potential risk and complication of submandibular gland removal surgery (*Id.* at 40-41). Dr. Borovik agreed that Dr. Carpenter's surgical note was limited, and that his post-operative notes contained discrepancies (Tr. 3/24/15, pp 82, 89, 93-94).

**G. The jury's finding of no professional negligence and Plaintiff's appeal.**

A special verdict form was provided to the jury which listed as its first question whether Dr. Carpenter was professionally negligent (*Id.* at 24-25). The jury returned later that afternoon with a 6-2 finding of no professional negligence (*Id.* at 25-26). A resulting judgment of no cause of action was entered on April 21, 2015 (**Exhibit E**).

Plaintiff's appeal followed. Defendant filed his cross appeal, asserting the alleged criminal conduct of Dr. Carpenter—unrelated to the medical treatment rendered to Plaintiff—should have also been excluded under MRE 608(b) in addition to MRE 403 (under which it was excluded), and that Plaintiff's theory of res ipsa loquitur was improperly presented to the jury and the jury was improperly instructed regarding this theory.

**H. The Court of Appeals Majority and Dissenting Opinions.**

As previously described, the Michigan Court of Appeals reversed and remanded for purposes of a new trial in a split decision (Majority Opinion, Owens, P.J. and Borrello, J.;

Dissenting Opinion, O'Brien, J.). The Majority found that the other acts testimony sought to be admitted by Plaintiff was probative under MRE 404(b) of whether Dr. Carpenter had a scheme, plan or system of recordkeeping serving to insulate him from liability in surgeries with poor outcomes, and that it would be unfair to exclude this evidence at the time of trial. The Majority did ***not*** identify, let alone balance, this alleged probative value against the prejudicial effect to the defense of the admission of the testimony (see particularly page 7 of the Majority Opinion). Likewise, in finding the exclusion of this testimony was not harmless, the Majority failed to analyze whether the ***relevant*** complaints of ***severe*** symptoms occurred during a timeframe supporting Plaintiff's theory of negligent surgery, and certainly did not analyze Plaintiff's concession that such severe symptoms did not even occur until 21 months after surgery.

The Dissent found that the other acts evidence was irrelevant because there was no claim that negligent recordkeeping in this case somehow contributed to Plaintiff's injury. Assuming there is some probative value to the testimony, the Dissent then found that the trial court did not abuse its discretion in excluding the testimony under MRE 403. Unlike the Majority, the Dissent identified and then analyzed the prejudice that would occur to the defense if the evidence was admitted, noting specifically that Defendant obviously would have the right to offer rebutting evidence in response to Dr. Morris' testimony (**Exhibit B**, p 7). Unlike the Majority, the Dissent actually looked at Plaintiff's offer of proof with respect to Dr. Morris' testimony, and found that the testimony—even if admitted—was insufficient to establish admissibility under MRE 404(b) (*Id.* at 5-7). Instead, the testimony simply reflected Dr. Morris' opinion about the adequacy of Defendant's recordkeeping.

The Dissent found that none of the other evidentiary challenges presented by Plaintiff had merit (addressed in Arguments II and III of Dr. Carpenter's Court of Appeals Brief on Appeal)

(**Exhibit B**, pp 8-9). Finally, the Dissent found that the trial court did abuse its discretion on instructing the jury on res ipsa loquitur because Plaintiff had only shown that an injury had occurred and that such an injury is rare absent negligence on behalf of the treating physician. The Dissent noted that both Plaintiff's and Defendant's experts testified that nerve injury is a known complication of submandibular gland excision and could occur without any negligence on behalf of the treating physician. As such, Plaintiff could not and did not satisfy the first element of res ipsa loquitur: the event must be of a kind which ordinarily does not occur in the absence of someone's negligence (*Id.* at 10-11).

After Dr. Carpenter filed his timely motion for reconsideration with the Court of Appeals, denied in the same 2-1 split by the Court of Appeals Judges, this application followed.

## THE NEED FOR SUPREME COURT REVIEW

The granting of leave to appeal is left to the sound discretion of the appellate court. *Armstrong v Commercial Carriers, Inc*, 341 Mich 45; 67 NW2d 194 (1994); *Sweitzer v Littlefield*, 297 Mich 356; 297 NW2d 522 (1941). Pursuant to MCR 7.305(B)(3) and (5), grounds for Supreme Court review include the presentation of an issue involving a legal principle of major significance to the Court's jurisprudence and, in an appeal from a decision of the Court of Appeals, a showing that the appellate decision is clearly erroneous and will cause material injustice, or that the decision conflicts with Supreme Court decisions or other decisions of the Court of Appeals. Each of these criterions is satisfied here. The Court of Appeals Majority Opinion presents the issue of whether a reviewing court can evaluate MRE 403 balancing by failing to define, let alone analyze, the prejudicial side of admission of the subject testimony. There can be no legitimate balancing when only one side of the MRE 403 equation—the probative side—is considered by the appellate court. Regardless of how a trial court may ultimately determine the probative value versus prejudicial effect of MRE 403, the functionality of the rule is destroyed if an appellate court finds an abuse of discretion without even analyzing one side of the equation: prejudicial effect. Given the frequency of evidentiary decisions made at the trial court level, and reviewed by the appellate courts, this issue carries major significance to Michigan's jurisprudence.

There is no meaningful discussion of the "abuse of discretion" standard in the Majority Opinion. Specifically, the Majority fails to apply the test enunciated by this Court and to explain ***how*** the trial court's MRE 403 ruling falls outside the range of principled outcomes. An appellate court may not legitimately find an abuse of discretion from a trial court's weighing of probative value versus prejudicial effect under MRE 403 when the appellate court fails to

identify, then consider, let alone properly determine, the prejudicial effect of the offending evidence. It is legally and logically impossible to find that a trial court has made an MRE 403 decision outside the range of principled outcomes when the appellate court does not analyze the prejudicial effect of the evidence in question. Moreover, as pointed out by the Dissent, the Majority finds an abuse of discretion based on the trial court's failure to admit evidence under a rule of evidence—MRE 404(b)—that was not argued to the trial court as a basis for the admission of the evidence. Judge O'Brien, recently elevated to the Court of Appeals from the trial court bench, found this conclusion "troublesome" (**Exhibit B**, p 3 fn 3). The Court of Appeals should not be in the habit of providing an "appellate lifeboat" to overturn discretionary rulings and grant new trials on the basis of arguments not made to the trial court. The proper application of an appellate standard of review is also of major significance to the State's jurisprudence.

The Majority Opinion is also contrary to the spirit, if not the exact letter, of this Court's decision in *Wischmeyer*, as well as the Court of Appeals decision of *Heshelman*. As such, conflicts exist between the Majority Opinion and existing case law from this Court and from the Court of Appeals.

Finally, it is unjust to strip from Dr. Carpenter a verdict of no cause of action on the incredibly tenuous finding of abuse of discretion under the errors previously described. The inequity of this ruling is compounded exponentially by ordering a new trial in which a jury will hear that Dr. Carpenter has been sued for malpractice by 8-10 of his other former patients. This propensity evidence carries a high degree of danger that the jury will focus upon the fact that these other cases were filed (not knowing whether there was a finding of liability or not) and wrongfully equate the filing of 8-10 lawsuits with the finding that Dr. Carpenter must have done

something wrong in the four corners of Plaintiff's case. Defendant respectfully submits that any other conclusion is naive, as is the Majority's observation that the defense can always ask for a limiting instruction on remand, which somehow would minimize or eliminate the danger of this propensity evidence.

The Dissenting Opinion is correct on all grounds. It protects the integrity of the abuse of discretion standard by discussing and then applying the standard to the four corners of this case, with appropriate deference to the trial court's firsthand, intimate knowledge of this case. Under its MRE 403 analysis, it defines and then actually balances the probative side ***and*** the prejudicial side of admitting the subject testimony. The Dissenting Opinion is grounded in a firm understanding of trial dynamics, in stark contrast to the Majority Opinion.

For all these reasons, Dr. Carpenter asks this Court to review the issues presented and grant the relief requested.

## ARGUMENT I

**THE COURT OF APPEALS MAJORITY OPINION ERRED BY DETERMINING THAT THE TRIAL COURT ABUSED ITS DISCRETION BY FINDING IRRELEVANT, AND ALTERNATIVELY FINDING INADMISSIBLE UNDER MRE 403, PLAINTIFF'S STANDARD OF CARE EXPERT'S TESTIMONY THAT HE HAD REVIEWED OTHER PATIENTS' MEDICAL RECORDS COMPILED BY DR. CARPENTER, PATIENTS WHO WERE PLAINTIFFS WHO HAD FILED LAWSUITS AGAINST DR. CARPENTER, FOR THE PURPORTED PURPOSE OF DEMONSTRATING THAT DR. CARPENTER'S RECORDKEEPING IN THIS CASE FOLLOWED A PATTERN OF INSUFFICIENT RECORDKEEPING WITH THESE OTHER PATIENT PLAINTIFFS.**

### A. Standard of review and supporting authority.

Several standards of review govern. The issue presented requires the court to interpret a number of rules of evidence, namely MRE 401, 402, 403, and 404. This Court reviews de novo the interpretation and application of rules of evidence. *Donkers v Kovach*, 277 Mich App 366, 369; 745 NW2d 154 (2007). The Court reviews for an abuse of discretion a trial court's ruling regarding the admission or exclusion of evidence. *Craig v Oakwood Hosp*, 471 Mich 67, 76; 684 NW2d 296 (2004). An abuse of discretion occurs when the decision results in an outcome falling outside the principled range of outcomes. *Novi v Robert Adell Children's Funded Trust*, 373 Mich 242, 254; 701 NW2d 144 (2005).

Even if a trial court's decision regarding the admission or exclusion of evidence is outside the range of principled outcomes, and found to be an abuse of discretion, reversal is not warranted unless a substantial right of a party is affected, MRE 103(a), or it affirmatively appears that the failure to grant relief is inconsistent with substantial justice. MCR 2.613(A). *See Lewis v LeGrow*, 258 Mich App 175, 200; 670 NW2d 675 (2003). Prejudicial error implies the conclusion that the substantial rights of the party were affected. *Ilins v Burns*, 388 Mich 504, 510-511; 201 NW2d 624 (1972).

## B. Argument.

### 1. The Majority necessarily erred by finding an abuse of discretion under MRE 403 when it failed to identify the prejudice to the defense by admitting the testimony, and accordingly engaged in only one-half of the "substantially outweighs" balancing test of MRE 403.

MRE 403 is explicit: although relevant, evidence may be excluded it if the probative value is "substantially outweighed" by, *inter alia*, danger of unfair prejudice or confusion of the issues. The trial court must balance the probative value of the proffered evidence against the unfair prejudice it would create. As previously explained, the trial court found both prejudice to the defense if the other acts evidence was admitted, as well as the strong potential for jury confusion by the interjection of Dr. Carpenter's recordkeeping for at least 8-10 other plaintiff-patients. Although the Majority does analyze and find that the other acts evidence is admissible and probative (the error of which is discussed *infra*), it failed to analyze altogether the prejudice that would result to the defense if the other acts evidence was admitted.[3] Instead, the Majority substitutes its conclusion that "[f]airness and accuracy demands that the jury be presented with sufficient evidence to determine" whether there was occasional charting errors or a "scheme,

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[3] "Third, the probative value of the evidence is not substantially outweighed by unfair prejudice. MRE 403 requires the exclusion of relevant evidence only where its probative value is substantially outweighed by unfair prejudice. Unfair prejudice refers to the tendency that the jury will give undue or preemptive weight to the evidence. *Franzel v Kerr Mfg Co,* 234 Mich App 600, 618; 600 NW2d 66 (1999). Here, the other acts evidence has substantial probative value in showing that defendant has a scheme or plan when it comes to charting that minimized his exposure to liability by not recording patients' post-operative complaints. Arguing to the contrary, defendant asserts that the probative value of admitting the records under 404(b) is limited, given defendant's admission that he occasionally makes charting errors and the testimony at trial establishing that plaintiff experienced various post-operative complications. Admitting to occasional charting errors is one thing; having a "scheme, plan or system" that insulates one from liability is another. Fairness and accuracy demands that the jury be presented with sufficient evidence to determine which it is. In addition, defendant always has the option of requesting an appropriate limiting instruction. MRE 105; *Lewis,* 258 Mich at 208."

(**Exhibit A**, p 6).

plan, or system" under MRE 404(b) in place of the requisite 403 balancing, adding that "defendant always has the option of requesting an appropriate limiting instruction." (**Exhibit A**, p 6). This is insufficient and requires reversal.

In *People v Watkins*, 498 Mich 450, 486; 818 NW2d 296 (2012), this Court found as error an application of MRE 403 that failed to evaluate the "two sides of the scale" in MRE 403. "As with any balancing test, MRE 403 involves two sides of the scale—a probative side and a prejudicial side." There is no indication in the four corners of the Majority Opinion that it considered the points of prejudice identified by the trial court, and those identified by Defendant on appeal. Appellate review, let alone reversal, of a decision under MRE 403 requires proper application of the rule by the appellate court. This is not a situation where the trial court makes a decision and fails to place its mental impressions upon the record, in support of admitting or excluding evidence at the time of trial. Although it may be argued that the trial court in such circumstances does not have an obligation to think out loud, it is axiomatic that the appellate court, which speaks through its written opinion, must properly apply each side of MRE 403 to the facts of the case. Absent identification and consideration of the prejudicial side of the scale, the Majority materially erred by finding that the trial court abused its discretion in performing the balancing test of MRE 403. A court "necessarily abuse[s] its discretion if it based its ruling on an erroneous view of the law or on a clearly erroneous assessment of the evidence." *Cooter Gell v Hartmax Corp*, 496 US 384, 405 (1990).

In this regard, the Majority's error is analogous to the failure to exercise discretion under the abuse of discretion standard. In such circumstances, this Court has held that "failure to exercise discretion when called on to do so constitutes an abdication and hence an abuse of discretion." *People v Stafford*, 434 Mich 125, 134, n 4; 450 NW2d 559 (1990). So too, failure

to identify and analyze the prejudicial side of MRE 403 is an abdication of fairly evaluating the trial court's balancing of the probative versus prejudicial factors of MRE 403.

The Majority Opinion's failure stands in stark contrast to the Dissenting Opinion, which both defined and balanced the probative and prejudicial sides of admission of the other patients' evidence (**Exhibit B**, p 7). "[A]llowing the admission of this testimony by Dr. Morris, who testified as an expert, requires and opens the door to an incredible amount of other evidence regarding these surgeries as well as other surgeries performed by the Defendant that reflect on his recordkeeping." *Id.* Whether the trial court abused its discretion upon considering this prejudice—as defined in the Dissenting Opinion and defined by the trial court at Tr. 3/17/15, pp 138-144—is discussed in the following pages. The point to be made for this specific argument is that the Majority Opinion failed to recite, let alone apply, the prejudice side of the subject evidence when overturning the trial court's MRE 403 weighing calculus.

**2. Prejudice and jury confusion.**

In the normal MRE 403 analysis, a litigant would present to this Court the probative value of a piece of evidence and then discuss how it is offset, and indeed outweighed, by the prejudicial effect of its admission. Given the trial court's clear enunciation of prejudice, which is established by this Court's decision in *Wischmeyer, supra*, Dr. Carpenter addresses the balancing test by first starting with the prejudice that would result to his case by the admission of Dr. Morris' testimony.

In *Wischmeyer*, this Court held that physicians who testify as expert witnesses in a medical malpractice case may be questioned about their own past poor outcomes because such information is relevant to the expert's competency and the weight to be given to his or her testimony. 449 Mich at 580. Here, there is no claim that Dr. Carpenter acted as an expert witness on his own behalf. In turn, *Wischmeyer*, as further framed by *Heshelman, supra*, stands

for the proposition that the mere fact that a physician has been sued for medical malpractice is not probative of his or her truthfulness, competency, or knowledge, and is thus inadmissible. See also *Persichini v William Beaumont Hospital*, 238 Mich App 626; 607 NW2d 100 (1999).

When Plaintiff sought to introduce evidence of other patient-plaintiff acts, by asking Dr. Carpenter whether he had ever failed to chart symptoms that were made known to him by other patients (Tr. 3/17/15, p 138), the defense objected and the trial court ultimately ruled under MRE 403 that such testimony would make the court and jury "try cases within cases" (*Id.* at 140), noting that counsel for Plaintiff could cross examine Dr. Carpenter on whether he made a mistake in the context of this case (*Id.* at 144). The trial court concluded: "If you're going to go into every other case that he's had and missed something, no." (*Id.*). Counsel for Plaintiff did not disagree with the trial court's characterization and reasoning, only with its legal ruling (*Id.* at 143-144).

If such evidence was admitted, it would have been impossible for Dr. Carpenter to have had a fair trial. The Majority failed to take into account the fact that Dr. Carpenter would have a right under due process considerations to rebut Dr. Morris' opinion that, based on his alleged review of eight to ten patient charts for former patients-plaintiffs who had filed cases against Dr. Carpenter, there was a pattern or method of poor recordkeeping. Defendant would have been obligated to explore the individual circumstances of each surgery, including the applicable standard of care for each instance and each patient's symptoms, medical histories, and outcomes. Imagine this process for the eight to ten individual patient-plaintiffs whose records Dr. Morris supposedly reviewed. There is huge potential for jury confusion by mixing and matching consideration of eight to ten other plaintiffs' malpractice cases with that of Ms. Merchand. The evidence carries the obvious fear underlying the danger of propensity evidence: it would have

diverted the jury's attention from the facts of the case being tried and focused that attention on the probability that the Dr. Carpenter, who has allegedly made mistakes before (as evidenced by the sheer number of medical malpractice cases filed against him) made one again in the matter to be resolved by the jury. *Wlosinski*, 269 Mich App at 312. In turn, such evidence would fatally taint any jury finding of liability, requiring the grant of a new trial. The propensity evidence concern is what underlies this Court's decision in *Wischmeyer* and the Court of Appeals decision in *Heshelman*, which this Court viewed favorably in *Wischmeyer*.

The trial court's finding of unfair prejudice is further supported by this Court's decision in *Zoterell v Repp*, 187 Mich 319, 330; 153 NW 692 (1959). "The bare fact that full recovery does not result, or the surgical operation is not entirely successful, is not in itself evidence of negligence." See also *Wlosinski*, 269 Mich App at 311 (holding that numerical success rates are not evidence that a doctor did anything wrong); *Roberts v Young*, 369 Mich 133, 138; 119 NW2d 627 (1963), quoting *Zoterell, supra.* Thus, if the jury were to be presented with evidence concerning eight to ten other medical malpractice cases brought against Dr. Carpenter, not only would the jury have a tendency to find that the number of cases brought against him must mean that he is a poor surgeon, but also that, in those cases, there were patients who did not have full recoveries, leading once again to the unfairly prejudicial notion that lack of full recovery means that a physician must have been negligent.

This is not to minimize the trial court's concern of a "case within the case," which is an independent basis for a finding of prejudice. Courts have found that a trial court can reasonably conclude that any probative value of an earlier alleged incident was outweighed by the specter of a "trial within a trial" when a plaintiff seeks to prove a physician's negligence in the action before the court. See e.g. *Armstrong v Hrabal, MD*, 87 P3d 1226, 1241 (Wyo 2004) (the court

finds no abuse of discretion by application of Wyoming Rule of Evidence 403—similar to Michigan's rule—of trial court's determination that plaintiff could not bring before the court other instances of alleged malpractice). Courts have likewise affirmed an exercise of discretion in non-malpractice cases prohibiting the admission of testimony that would turn the case into a series of mini-trials. See e.g., *Martinez v Cui*, 608 F2d 54, 61 (CA 1, 2010) (excluding testimony in part because it would lead to a "minitrial"); *United States v Gilbert*, 229 F3d 15, 24 (CA 1, 2000) (excluding evidence in part because it would lead to a "mini-trial" with "the potential for confusion of the issues and for unfair prejudice"); *United States v Rodriguez-Soler*, 773 F3d 289, 294 (CA 1, 2014). *Freeman v Package Machinery Co*, 865 F2d 1331, 1340 (CA 1, 1988). This case does not present an "extraordinarily compelling circumstance[]" that would lead an appellate court to reverse a district court's judgment about the probative value and unfair effect of evidence. See also *Lund v Henderson*, 807 F3d 6, 11-12 (CA 1, 2015) (citing these cases).

The United States Supreme Court has found that the deference accorded to a trial court in its evidentiary rulings is particularly appropriate with respect to an FRE 403 determination, since such determinations require an on-the-spot balancing of probative value and prejudice, potentially to exclude as unduly prejudicial some evidence that already has been found to be factually relevant. *Sprint/United Mgt Co v Mendelsohn*, 552 US 379, 384 (2008). "With respect to evidentiary questions in general and Rule 403 in particular, a district court virtually always is in the better position to assess the admissibility of the evidence in the context of the particular case before it." *Id*. at 387. Similarly, this Court has stated that MRE 403 determinations "are best left to a contemporaneous assessment of the presentation, credibility, and effect of the testimony of the trial judge." *People v Bahoda*, 448 Mich 261, 289-291; 531 NW2d 659 (1995).

The prejudice resulting from disclosure to the jury of eight to ten other patient-plaintiffs is not diminished by the evidence's alleged probative value under MRE 404(b). See, e.g. *Weil v Seltzer*, 873 F2d 1453, 1461 (DC Cir 1989) (new trial granted when trial court allowed plaintiff to present evidence of defendant physician's treatment of five testifying plaintiffs); *Outley v City of New York*, 873 F2d 587, 592-593 (CA 2, 1988) (evidence of six prior lawsuits filed by litigant improper under Rule 404(b) because it is improper evidence of character trait or litigiousness); *Carter v District of Columbia*, 795 F2d 116, 131 (DC Cir 1986) (admission of police officer's personnel files containing evidence of other bad acts was error because it subjected officer to risk unfair prejudice).

The Majority did not take into account any of the following considerations arising from Plaintiff's proposed introduction of introduce evidence of other patients' complaints regarding Dr. Carpenter's treatment in other cases:

a. Counsel for Dr. Carpenter would have been obligated to explore the individual circumstances of each surgery, including the applicable standard of care and each patient's symptoms, medical history, and outcomes.

b. The subset of patients chosen by Plaintiff to show inadequate recordkeeping—all plaintiffs—is inherently biased, bias which the defense would have the right to explore, spinning off into a series of mini-trials.

c. The medical records of 8-10 patient-plaintiffs reviewed by Dr. Morris did not constitute an adequate and indicative sampling of Dr. Carpenter's recordkeeping—they were cherry-picked from patients who had brought claims against Dr. Carpenter, and who were represented by counsel for Plaintiff (or related counsel) in then-pending cases against Dr. Carpenter. In turn, Defendant would have a right to bring in other patients, their charts, and their experiences, to balance out this biased sampling. However, as addressed next…

d. How would Dr. Carpenter establish a proper representative sampling of patients in the midst of trial when the medical

> information is obviously privileged to the other non-plaintiff patients, and the defense does not have meaningful access to such a list of such other patients?

The Dissent recognized these points of prejudice when finding that the trial court did not abuse its discretion in its MRE 403 calculus (**Exhibit B**, p 7). Again, all of this assumes that the evidence is relevant and there is sufficient probative value to justify the MRE 403 weighing in the first instance (discussed in subsections 4 and 5, *infra*).

In *Cetlinski v Brown, MD*, 91 Fed Appx 384 (CA 6, 2004) (**Exhibit F**), the plaintiff sought to present testimony by a physician's other patients to demonstrate that the physician had performed an experimental procedure on the prosecuting plaintiff without obtaining informed consent. The district court found that there was a substantial danger of unfair prejudice and confusion of the issues that would engender undue delay, and thus ruled admissible of the evidence under FRE 403. The court reasoned:

> "The admission of the testimony would have created a substantial danger of unfair prejudice and of confusion of issues and would have engendered undue delay. The defendants would have been compelled to respond with evidence that the surgeries were successful, generating a series of "mini-trials" on the adequacy of Brown's treatment of his other patients. Presented with this evidence, the jury may well have fastened on ancillary issues or have considered the testimony of the other patients for improper purposes (*e.g.*, it may have punished Brown for his negligence in treating the other patients). And, unquestionably, the proceedings would have been prolonged significantly—just to allow for the introduction of evidence of dubious value. In short, the probative value of the testimony was substantially outweighed by the factors favoring exclusion, and the evidence was properly excluded under Fed. R. Evid. 403."

91 Fed Appx at 394.

*Cetlinski* is especially insightful because it brings together all of the MRE 403 prejudice factors—prejudice, case within the case concerns, undue delay, and jury confusion—and finds in the aggregate that such considerations justified the trial court's exclusion of testimony of other patient evidence and testimony against a physician accused of professional malpractice. Each of

those factors applies here, with greater force given Plaintiff's inability to place the sought-after testimony in any reasonable context, the obvious prejudice resulting from the propensity nature of the testimony, and the necessary deference to the trial court's 403 ruling under the abuse of discretion standard of review.

**3. A limiting instruction would not have cured the abject prejudice to the defense.**

The Majority suggests that, on remand, Dr. Carpenter would have the option of requesting an appropriate limiting instruction under MRE 105 (**Exhibit A**, p 6). There are two problems with this observation. First, proffering a limiting instruction does not cure the Majority's failure to define and then consider the prejudicial side of MRE 403. Second, it is unrealistic to believe that a limiting instruction would be effective in these circumstances. According to Plaintiff's sought-after proofs, the jury would learn that there were 8-10 former patients, all plaintiffs, who contend that Dr. Carpenter breached the applicable standard of care in their cases. Not only would the jury have a tendency to find that the recordkeeping allegations in those cases meant there was a recordkeeping issue in this case, but that the mere fact that Dr. Carpenter had been sued on so many occasions would mean that, without regard to how those cases were or would be resolved, Dr. Carpenter must be negligent in this case (why else would so many cases be filed against him?). This is the classic propensity evidence prohibited under *Wlosinski, supra*. Telling the jury that it is not to consider the "other patients'" evidence when determining whether Dr. Carpenter breached the standard of care in this case would realistically do nothing to prevent jurors from drawing prejudicial inferences from the fact that other patients had sued Dr. Carpenter for medical malpractice.

**4. The other acts testimony was irrelevant.**

As a necessary predicate to find that the trial court abused its discretion under MRE 403, the Majority was required to and indeed did assign both relevance and probative value to the other acts testimony. Its determinations are simply incorrect under the facts of the case. As explained in the Statement of Facts, the only theory of liability brought against Dr. Carpenter was negligent surgery. There was no claim that Dr. Carpenter's alleged failure to adequately record surgery complications or post-operative symptoms played any role in Plaintiff's injury. Instead, Plaintiff claimed exclusively that Dr. Carpenter injured her HGN ***during*** the surgery at issue, and did not point to any conduct ***after*** the time of the surgery as a basis for finding negligence. Thus, Dr. Carpenter's alleged inaccurate recordkeeping does not have a tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the testimony. MRE 401. Specifically, whether Dr. Carpenter allegedly injured Plaintiff's HGN in the course of surgery is not made more or less probable by his alleged recordkeeping deficiencies in recording the symptomology after the surgery. It is important to note that Plaintiff did not ever pursue recovery under theories with any relevance to recordkeeping, such as the failure to properly recognize post-surgery complications or address post-operative symptoms. As explained in subsection 6, *infra*, not only is the other acts evidence irrelevant, its exclusion is necessarily harmless.

**5. If relevant, the other acts evidence was minimally probative.**

When finding the evidence was admissible and had probative value, the Majority cited to MRE 404(b) (which was not the proffered basis for admission in the trial court), and determined that the other patients evidence was admissible to prove, *inter alia*, a "scheme, plan, or system" of deficient recordkeeping by Dr. Carpenter. As previously explained, such a "scheme, plan, or system" is irrelevant to whether Dr. Carpenter properly performed the surgery because the

recordkeeping deals with events after the time of the asserted malpractice. The Majority found that Dr. Morris' testimony reveals parallels between this case and the records in Dr. Carpenter's other medical malpractice cases (**Exhibit A**, p 4). This overstates the value of Dr. Morris' testimony, taken from the special record presented to the trial court (Tr. 3/23/2015, pp 162-165). None of the special record testimony reflects evidence of a "scheme, plan, or system," but rather is simply an expert's opinion about the adequacy of Dr. Carpenter's recordkeeping in other cases. Moreover, the testimony elicited from Dr. Morris during the special examination dealt with matters such as the meticulousness of Dr. Carpenter's dissections "during surgeries" (*Id*. at 164), and the details of injuries allegedly sustained during those surgeries (*Id*. at 164-165), and otherwise does not reasonably provide sufficient evidence to establish even a *prima facie* case of a system, plan, or scheme in deficient recordkeeping. Plaintiff did not present sufficient evidence through the special record to trigger the alleged admissibility of the other patients evidence under MRE 404(b)(1).

**6. The exclusion of the other patient-plaintiffs evidence is harmless.**

It is incumbent upon the appealing party to show the existence, not just the possibility, of prejudice by the admission or exclusion of evidence. *Ilins, supra*. MCR 2.613(A) instructs that any error in the exclusion of evidence is not ground for granting a new trial unless the refusal to take the action appears to the court inconsistent with substantial justice.

Here, there are two reasons why the alleged error is necessarily harmless. First, the evidence was cumulative. Plaintiff did not need to proffer evidence of other patients' complaints and alleged poor recordkeeping to cast aspersions on Dr. Carpenter's recordkeeping in this case, because Plaintiff elicited admissions from Dr. Carpenter that his medical records for patients

were not completely accurate, and that he was sure he had mischarted some patient information on occasion (Tr. 3/17/15, p 151).[4] These admissions, coupled with the extensive testimony from Plaintiff, her family members and her treating doctors regarding the alleged early onset of her symptoms, were more than sufficient for Plaintiff to make the case to the jury that the supposed absence of Plaintiff's early complaints in Dr. Carpenter's records should not be taken as evidence that those symptoms did not exist soon after Plaintiff's surgery. Additionally, as the trial court aptly noted, the absence of complaints in other patients' charts does not constitute evidence that Plaintiff either had the symptoms she claimed to have, or that Dr. Carpenter failed to document them (*Id*. at 147-148). The same is true for evidence of other allegedly negligent surgeries, only one of which was the same surgery performed on Plaintiff (but also involved a tumor removal), and none of which involved injury to the hypoglossal nerve. Dr. Carpenter's testimony regarding his surgical technique was limited to submandibular gland removal, and any allegations that he performed different surgeries negligently would not establish that he performed Plaintiff's surgery negligently. Plaintiff adequately cross examined Dr. Carpenter regarding the speed with which he performed Plaintiff's surgery, and her experts suggested that this speed could be equated with recklessness.

In related fashion, Defendant's credibility as a fact witness at trial was not crucial to determining whether he was negligent in performing Plaintiff's surgery. Dr. Carpenter had no independent recollection of Plaintiff's surgery at trial. Instead, he testified as to his usual pattern

[4] Dr. Carpenter testified that it was "possible" Plaintiff had made her post-operative issues known to him, but he did not remember because he had no personal recollection of her care and his records were silent as to that issue (Tr. 3/17/15, p 132). He also testified that he was not specifically aware of, and did not recall becoming aware of, any patients making known to him that they were having symptoms of nerve problems following his surgeries that went uncharted (*Id*. at 137-138).

and practice of performing submandibular gland removals, and referred to his operative notes. As previously mentioned, Plaintiff extensively cross examined Dr. Carpenter regarding the alleged omissions, deficiencies and inconsistencies in his patient notes, eliciting several admissions that the records were incomplete or inconsistent. Plaintiff's experts likewise criticized the operative note as incomplete and deficient, and the post-operative records as contradictory and lacking in substance. In other words, the jury did not have to evaluate Dr. Carpenter's credibility as a fact witness in terms of his recollection of the facts of the case, because the relevant facts came from his records and from the testimony of Plaintiff, her family members, and her treating physicians based on their personal recollections.

Second, the accuracy of Plaintiff's post-operative records and whether they document all of her reported symptoms was not an issue which would affect the outcome of this case, which turned out to be a classic "battle of the experts." Plaintiff claims that the post-operative records are essential to establishing the timeline of her symptom progression, which controls the parties' respective theories of the case. However, both parties' theories are in fact consistent with the record evidence of when Plaintiff's symptoms developed. Plaintiff's theory, as explained by Dr. Schechter, was that the delayed onset of Plaintiff's more severe symptoms (fasciculations, deviation, etc.) as reflected in the post-operative records was entirely consistent with injury to the hypoglossal nerve on the date of surgery (Tr. 3/20/15, pp 28-31, 62). This is because Plaintiff's experts believed that the emergence of HGN injury symptoms is progressive, with the symptoms worsening over the span of months or years. Thus, the fact that, according to the medical records, Plaintiff did not report deviation or fasciculations until she saw Dr. McLaughlin in May 2012 was not inconsistent with their theory that these symptoms start mild (i.e., the tongue biting, drooling and swallowing reported by Plaintiff and her family immediately after surgery)

and worsen over time. In contrast, Defendant's theory was that the absence of *serious* complaints regarding Plaintiff's tongue in Dr. Carpenter's post-operative records meant that Plaintiff did not suffer hypoglossal nerve injury during surgery because those symptoms (deviation, palsy and fasciculations) would have been apparent immediately after surgery or up to 2-3 months later, at most.

It is important to note that the symptoms Plaintiff alleges were absent from Dr. Carpenter's records were not the major, severe symptoms (deviation, palsy and fasciculations) which Defendant's experts claim would have established nerve injury at the time of surgery. Rather, Plaintiff claims that Dr. Carpenter failed to document her early complaints of tongue biting, spitting and difficulty talking and swallowing in the days and months after her surgery. What this means is that the alleged discrepancies and omissions from Dr. Carpenter's records (which Plaintiff contends were relevant and probative) were in fact not necessary at all to proving Plaintiff's theory or disproving Defendant's theory. Plaintiff presented ample evidence of these minor symptoms through the testimony of herself, her family and her treating physicians (and other medical records). The evidence in the case lent equal support to both parties' theories of hypoglossal nerve damage and their respective arguments about whether the damage occurred during surgery. The jury was faced with the choice between the two theories, and found that either Defendant's theory was more credible, or that Plaintiff's theory was not credible enough. The substantive and outcome-determinative difference between the two theories of liability was the experts' differing theories as to the progression of the symptoms of hypoglossal nerve damage.[5] Neither Dr. Carpenter's testimony nor his records were probative of whether

[5] This difference of opinion is relevant to both causation and the standard of care, as both parties' experts used the progression of symptoms to determine that Plaintiff's hypoglossal nerve injury *(cont'd next page)*

Plaintiff's theory of slow symptom progression or Defendant's theory of immediate, severe symptom manifestation was correct. Thus, any error in exclusion of evidence bearing on Dr. Carpenter's credibility or the accuracy of his records was harmless.

Finally, to the extent that any of the excluded evidence touched upon the questions of proximate cause or damages, or Plaintiff's ability to prove those elements of her malpractice claim, the exclusion is necessarily harmless because the jury never reached those issues, having found Dr. Carpenter was not professionally negligent. When error arises from the question of proximate cause, yet the jury never reached that point in the trial, the error is considered harmless under Michigan law. *Jackson v Coeling*, 133 Mich App 394, 401; 349 NW2d 517 (1984) ("any error was harmless, because the jury did not reach the question of proximate cause."). So too, when the alleged error relates to the question of damages, which is never reached by the jury, any error is necessarily harmless. *Beadle v Allis*, 165 Mich App 516, 525; 418 NW2d 906 (1987) (where jury returned with a verdict of no cause of action and instruction error claimed with respect to the issue of damages, reversal is not required).

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*(cont'd from previous page)*

either did occur at the time of surgery from Dr. Carpenter's negligence, or could not have occurred at the time of surgery, meaning that he was not negligent.

## ARGUMENT II

**THE TRIAL COURT ERRED BY DETERMINING THAT PLAINTIFF HAD PROPERLY PLED RES IPSA LOQUITUR AND THAT IT APPLIED IN THE FACTS OF THIS CASE, UNDER WHICH RULING THE TRIAL COURT NOT ONLY ERRONEOUSLY INSTRUCTED THE JURY PURSUANT TO M CIV JI 30.05 [RES IPSA LOQUITUR], BUT ALSO REFUSED TO INSTRUCT THE JURY UNDER M CIV JI 30.04 [MEDICAL UNCERTAINTIES].**

### A. Standard of review and supporting authority.

The Court is referred to the corresponding subsection in Argument I. Further, "this Court reviews de novo whether the doctrine of res ipsa loquitur applies to a particular case." *Groesbeck v Henry Ford Health System,* Court of Appeals Docket No. 307069, *rel'd* February 26, 2013 (unpublished); 2013 WL 951090 (**Exhibit G**), citing *Jones v Porretta*, 428 Mich 132, 154 n8; 405 NW2d 863 (1987). This Court reviews de novo claims of instructional error, examining jury instructions as a whole to determine if there is error requiring reversal, and whether failure to reverse would be inconsistent with substantial justice. *Case v Consumers Power Co*, 463 Mich 1, 6; 615 NW2d 17 (2000).

### B. Introduction-summary.

The trial court erred by deciding that Plaintiff could argue res ipsa loquitur in the context of this case. Plaintiff failed to establish that this type of case, and this case in particular, satisfy the requirements of the rule. For that reason, the jury should not have been instructed on the doctrine and, in turn, the trial court would have—and should have—instructed the jury pursuant to M Civ JI 30.04. Additionally, the doctrine was not preserved by way of pleading or otherwise and should not have been allowed to be presented at the time of trial.

**C. Governing law.**

**1. Res ipsa loquitur.**

The purpose of the doctrine of res ipsa loquitur is to create an inference of negligence where the plaintiff is unable to prove the occurrence of a negligent act. *Cloverleaf Car Company v Phillips Petroleum Company*, 213 Mich App 186, 193-194; 540 NW2d 297 (1995). According to Prosser & Keeton Torts (5th ed), § 39, p 244, to utilize this doctrine, the plaintiff must establish the following conditions:

> "1. The event must be of a kind which ordinarily does not occur in the absence of someone's negligence;
>
> 2. It must be caused by an agency or instrumentality within the exclusive control of the defendant;
>
> 3. It must not have been due to any voluntary action or contribution on the part of the plaintiff."

*Jones*, 428 Mich at 150-151. This Court has noted a fourth criterion: "Evidence of the true explanation of the event must be more readily accessible to the defendant than to the plaintiff." *Id.* at 151; *Wilson*, 411 Mich at 607.

Application of the rule of res ipsa loquitur is limited in medical malpractice cases. "It is the general rule, in actions for malpractice, that there is no presumption of negligence from the mere failure of judgment on the part of the doctor in the diagnosis or in the treatment he has prescribed, or from the fact that he has been unsuccessful in effecting a remedy, or has failed to bring about as good a result as someone else might have accomplished, or even from the fact that aggravation follows his treatment." *Jones*, 428 Mich at 151-152, quoting with approval Shain, *Res Ipsa Loquitur*, 17 S Cal LR 187, 217 (1944).

This Court has emphasized that the issue of whether an event does not ordinarily occur in the absence of negligence "must either be supported by expert testimony or must be within the

common understanding of the jury." *Woodard v Custer*, 473 Mich 1, 7; 702 NW2d 522 (2005), quoting *Locke v Pachtman*, 446 Mich 216, 231; 521 NW2d 786 (1994).[6]

Panels of the Court of Appeals have found that a plaintiff must plead res ipsa loquitur in the complaint to preserve its availability at trial. *Badalamenti v William Beaumont Hospital-Troy*, 237 Mich App 278, 284; 602 NW2d 854 (1999); *Via v Beaumont Health System*, Court of Appeals Docket No. 316776, *rel'd* October 21, 2014 (unpublished); 2014 WL 5364119 (**Exhibit H**).

**2. Applicable medical malpractice jury instructions.**

M Civ JI 30.04 [Medical Malpractice: Cautionary Instruction on Medical Uncertainties] provides:

> "There are risks inherent in medical treatment that are not within a doctor's control. A doctor is not liable merely because of an adverse result. However, a doctor is liable if the doctor is negligent and that negligence is a proximate cause of an adverse result."

M Civ JI 30.05 [Medical Malpractice: Permissible Inference of Malpractice From Circumstantial Evidence (Res Ipsa Loquitur)] provides:

> "If you find that the defendant had control over the [ body of the plaintiff / instrumentality which caused the plaintiff's injury ], and that the plaintiff's injury is of a kind which does not ordinarily occur without someone's negligence, then you may infer that the defendant was negligent.
>
> However, you should weigh all of the evidence in this case in determining whether the defendant was negligent and whether that negligence was a proximate cause of plaintiff's injury."

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[6] "Although res ipsa loquitur is a doctrine of common sense, expert testimony is required where the issue of care is beyond the realm of the lay person, that is, where a fact-finder cannot determine whether a defendant's conduct fell below the applicable standard of care without technical input from an expert witness."

*Maroules v Jumbo, Inc*, 452 F3d 639, 644 (CA 7, 2006).

In *Jones*, 428 Mich at 156, this Court noted that when the res ipsa loquitur instruction is given under M Civ JI 30.05, the Court should not instruct under M Civ JI 30.04 on medical uncertainties.

**D. Argument.**

As addressed next in subsection 1, res ipsa loquitur is inapplicable to this case. Although Plaintiff's expert Dr. Morris, testified that injury to the hypoglossal nerve does not occur during submandibular gland removal surgery in the absence of negligence, he conceded that such an injury is a known risk and complication of this surgery, and may occur by reason of other means (namely, infection). In light of this concession, along with the unified and supportive testimony of the defense experts that such injury does occur in the absence of negligence and is a known and accepted complication of this procedure, the trial court should not have instructed the jury on res ipsa loquitur. In turn, the trial court was then free to instruct the jury on medical uncertainties, which the defense had requested.

As addressed in subsection 2, the trial court erred by determining that Plaintiff had preserved the right to assert res ipsa loquitur when the theory was never enunciated in Plaintiff's notice of intent, complaint, or affidavit of merit. Significant Michigan case law supports the proposition that the doctrine should therefore be withheld at the time of trial.

**1. Res ipsa loquitur does not apply to this case.**

Plaintiff did not demonstrate application of each of the res ipsa loquitur factors, in particular showing that the event (severing of the hypoglossal nerve) was of a kind that does not ordinarily occur in the absence of someone's negligence (namely Dr. Carpenter's surgery).

In arguing for res ipsa loquitur, Plaintiff pointed to the testimony of her standard of care expert, Dr. Morris, who stated that injury to the hypoglossal nerve during the subject surgery was

an event that would not ordinarily occur in the absence of negligence (Tr. 3/23/2015, p 87). Not only was this opinion contrary to those of Dr. Rontal[7] and Dr. Borovik[8], but it was contrary to Dr. Morris' admission that injury to the hypoglossal nerve is a recognized complication of a submandibular gland excision surgery (*Id.* at 124-126). Indeed, Dr. Morris admitted that, with respect to his patients undergoing these surgeries, he counsels the patients on the fact that hypoglossal nerve injury is a "recognized potential complication that can occur." (*Id.* at 126). Thus, where Dr. Morris admitted that he did not know exactly what Dr. Carpenter had done during the course of the dissection (because it wasn't specifically described in the operative note) (*Id.* at 135), and that the only way of knowing whether a consequence of surgery was affecting the nerve was to know what actually happened during the surgery (*Id.*), Dr. Morris could not reliably state that 100% of the time, "without exception," when an injury occurs to the hypoglossal nerve during this surgery, it must be a result of the physician breaching the standard of care, especially when he himself would tell his patients that there was a potential risk to the hypoglossal nerve with this dissection (*Id.* at 159-160).

It is inconsistent for an expert witness to opine on one hand that injury necessarily occurs by reason of the mere performance of the operation, yet admit that the consequence of that operation—here damage to the hypoglossal nerve—is a known and accepted complication of the surgery, as the expert advises his own patients. This is insufficient testimony upon which

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[7] At trial, Dr. Rontal explained to the jury that a problem could occur with the hypoglossal nerve during the performance of this surgery, notwithstanding the exercise of due care, because of the limited view of the surgical field (Tr. 3/24/2015, pp 146-147).

[8] At trial, Dr. Borovik explained to the jury that there are recognized potential risks and complications relating to submandibular gland removal surgery, including nerve injury (Tr. 3/24/2015, pp 40-41). He explained that complications with the nerves in this area develop even though a surgeon is acting within the standard of care because of the unpredictability of the surgery and matters that can take place outside the surgeon's control (*Id.* at 41).

Plaintiff may "grasp the *res ipsa loquitur* lifeline." *Pulley v The Gillette Co*, 1994 US Dist LEXIS 17659, *rel'd* October 13, 1994 (ED Mich 1994) (unpublished) (applying Michigan law) (**Exhibit I**).

Nerve injuries during surgery are oftentimes considered inherent risks and complications of the procedure.[9] It follows that the mere act of surgery and the concomitant injury to a nerve do not equate with negligence. Injury could be due to the complexity of the human body, including anatomical differences such as aberrant locations of the nerve, the interconnection between nerve tissue and aberrant amounts of fibrous tissue, all found within the close quarters of the surgical field. In essence, sometimes it is not humanly possible to identify tissues bound up together. Thus, when there is an inherent risk of surgery that involves injury to a nerve – as demonstrated by the multiple cases cited above – the notion of inherent risks eliminates the propriety of res ipsa loquitur.

In the lower court, Plaintiff also argued that the "facts and circumstances" of this case allowed the application of res ipsa loquitur, primarily pointing to the testimony of Dr. Morris (Tr. 3/23/2015, pp 77-78). The flaw in this argument is that the first element of res ipsa loquitur requires the event be "of a ***kind***" which ordinarily does not occur in the absence of someone's negligence. Plaintiff counts on the proposition that the most likely explanation for the event –

[9] See *Schroeder v Lawrence*, 359 NE2d 1301, 1302 (Mass 1977) (witness stated "any operative procedure on the thyroid gland involves an inherent and well known risk of injury to the recurrent laryngeal nerve"); *Mattie v Sacred Heart Hospital*, 1992 WL 1071358 (Pa Com Pl, January 29, 1992) (expert testified an injury to the recurrent laryngeal nerve is an inherent risk of a thyroidectomy) (**Exhibit J**); *Melancon v LaRocca*, 650 So2d 371, 373 (La App 1995) (injury to recurrent laryngeal nerve is inherent risk of anterior cervical fusion); *Kuykendall v Dragun*, 2006 WL 728068 at *2 (Tex App-Eastland 2006) (**Exhibit K**); *Menard v Holland*, 919 So2d 810, 814 (La App 2006); *Lindner v Hoffman*, 894 So2d 427, 431 (La App 2005); *Hahn v USC University Hospital*, 2005 WL 1253907 at *5 (Cal App 2005) (**Exhibit L**); *Lewis v Toledo Hospital*, 2004 WL 1368205 at *1 (Ohio App 2004) (**Exhibit M**); *Au v Leung*, 2002 WL 1357099 at *3 (Cal App 2002) (**Exhibit N**).

hypoglossal nerve damage – is the same as demonstrating that this event is of a kind that ordinarily does not occur in the absence of someone's negligence. In so arguing, Plaintiff sought to satisfy the first element of res ipsa loquitur by essentially redefining it.

Moreover, Dr. Morris did not account for the fact of infection which occurred eight days after the operation with respect to his monolithic opinion that the fact of injury to the hypoglossal nerve proves it must have resulted from Dr. Carpenter's negligent surgery (see e.g. Tr. 3/23/2015, pp 141-143). And he candidly admitted that inflammation with infection after surgery can sometimes affect nerve function, at least temporarily or possibly permanently (*Id.* at 145). Moreover, he defined the condition as benign, meaning that it involved an infection (*Id.* at 150). The sum and substance of this testimony is Dr. Morris ***admitted*** to another precipitating factor for hypoglossal nerve injury – infection – that obviously has nothing to do with the improper surgery allegedly performed by Dr. Carpenter. Through this testimony alone, as elicited from Plaintiff's expert, res ipsa loquitur cannot apply because Plaintiff could not demonstrate that the event – HGN injury during this procedure – necessarily resulted from Dr. Carpenter's surgery, let alone is the type of event that ordinarily does not occur in the absence of negligence.

Additionally, it was inappropriate to instruct the jury on res ipsa loquitur, premised on the assertion that injury to the hypoglossal nerve would not occur absent Dr. Carpenter's negligence, when there was discrete testimony that such injury did not occur at all. Again, the defense theory was that such an injury, if it occurred, would have manifested itself in immediate symptomology (including loss of motor control), whereas here Plaintiff did not disclose such symptomology—if at all—until almost two years after the procedure. See Dr. Borovik's testimony at Tr. 3/24/2015, pp 61-62, 65, 67, and 70. There were no reports that Plaintiff

complained of any deviation of her tongue as of March 2011 (*Id*. at 64), or that Plaintiff had fasciculations of her tongue any time before April 2012 (*Id.* at 65), all of which would have been noticeable immediately after the injury to the hypoglossal nerve, if it occurred (*Id.* at 66-67). See also Dr. Rontal's testimony, *Id.* at 164-167.[10]

Finally, notwithstanding the expert testimony of Dr. Morris, it must be conceded that whether the hypoglossal nerve was injured during this procedure is not within the common understanding of the jury. *Locke,* 446 Mich at 231. As demonstrated, the expert testimony here is insufficient to allow for res ipsa loquitur, given the concession that the injury to the hypoglossal nerve is an inherent and known risk of the complication, of which Dr. Morris advises his patients. Moreover, Dr. Morris' opinion that an HGN injury always occurs by reason of negligence, without exception, is insufficient to satisfy either the expert testimony requirement or the common understanding of the jury requirement of res ipsa loquitur. *Elher v Misra*, 308 Mich App 276, 310-312; 870 NW2d 335 (2014), *rev'd on other grounds*, 499 Mich 11; 878 NW2d 790 (2016).

If this Court agrees with the defense analysis, then it necessarily follows that Plaintiff was not entitled to a jury instruction on res ipsa loquitur (and would not be so entitled on

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[10] "Q. Did you see any evidence in this case from your review of the records indicating that Ms. Merchand had paralysis of the tongue, deviation of the tongue, or fasciculations develop within that immediate post op. or within three or four months?

A. [By Dr. Rontal] No. And that's the reason I don't think anything was done wrong in the operating room is that there was no evidence of that at any point in this case from the time the patient left the operating room until May of 2012 when she went and saw Doctor McLaughlin and said, something's wrong with my tongue. That's almost 21 months following the surgery and no complaints until she sees Doctor McLaughlin in May of 2012.

If this patient had had the hypoglossal nerve cut, she would have been screaming because - - saying there's something wrong, why can't my tongue move? Why can't I talk right? Why can't I swallow?"

(*Id*. at 164-165).

remand), and that Defendant would instead be entitled to the medical uncertainties instruction. The reason why the trial court refused to give the latter is because of its misperceived need to give the former (Tr. 3/26/2015, pp 56-57), and its determination that the instructions were inconsistent under *Jones, supra* (*Id.*). A standard jury instruction must be given when requested by a party if it is applicable based on the characteristics of the case and accurately states the law. MCR 2.516(D); *Chastain v General Motors Corp (On Remand)*, 254 Mich App 576, 590; 657 NW2d 804 (2002); *Stevens v Veenstra*, 226 Mich App 441, 443; 573 NW2d 341 (1997). The court is charged to determine the propriety of an instruction in the context of the "personality" of the particular case and with due regard for the parties' theories of the case. *Johnson v Corbet*, 423 Mich 304, 327; 377 NW2d 713 (1985). Here, based on the testimony of all the experts, especially that of Doctors Rontal and Borovik, that injury to the hypoglossal nerve is a recognized and known complication of which physicians advise their patients, the medical uncertainties instruction found at M Civ JI 30.04 is clearly applicable and should have been given.

**2. Failure to plead and preserve res ipsa loquitur.**

Plaintiff did not preserve her right to application of res ipsa loquitur at the time of trial. As explained in the Statement of Facts, Plaintiff alleged in her complaint only that Dr. Carpenter failed to properly identify and protect the hypoglossal nerve from injury during the procedure. Plaintiff alleged that, had Dr. Carpenter identified and protected the hypoglossal nerve, it would not have been injured. These are the claims supported by Dr. Morris's affidavit of merit. However, Plaintiff did not plead a res ipsa loquitur claim in the complaint. Nor did Dr. Morris's affidavit of merit support such an inference. Here are the facts.

Plaintiff served her notice of intent in this case on July 9, 2012, asserting that the surgery was not indicated and/or that informed consent was not obtained (**Exhibit O**, pp 14-15). After

the notice period ended, Plaintiff filed her complaint and affidavit of merit signed by Dr. Michael Morris (each found at **Exhibit E**). The complaint and affidavit of merit recited the breaches of the standard of care identified in the notice of intent. However, the complaint and affidavit of merit omitted any allegations the surgery was not indicated or informed consent was not obtained. Plaintiff abandoned these claims and only pled Dr. Carpenter failed to properly perform the submandibular gland procedure so as to avoid injury. Nowhere in her pleadings, either in her affidavit of merit or complaint, did Plaintiff plead a claim for res ipsa loquitur or even the facts necessary to invoke the doctrine.

The pleading requirements in Michigan require all theories to be properly and timely asserted. In a medical malpractice case, the pleadings must specifically state the exact theories of negligence intended to be established at trial. *Serafin v Peoples Community Hospital Authority*, 67 Mich App 560, 565; 242 NW2d 438 (1976); *Stanek v Bergeon*, 89 Mich App 283, 286; 279 NW2d 296 (1979). In fact, in a medical malpractice case, a party's proofs are limited to those allegations pleaded. *Badalamenti*, 237 Mich App 278. A party may thus not otherwise seek to expand his or her allegations beyond those included in the complaint without leave to amend from the court. *Bishop v St. John Hospital*, 140 Mich App 720; 364 NW2d 290 (1984). Moreover, a party is precluded from adding a new theory of liability on the eve of trial where the party did not give reasonable notice to the defense that it would have to defend against such allegations. *Kemp v Harper-Grace Hospital*, 180 Mich App 473; 447 NW2d 780 (1989).

In like fashion, Michigan law demands the plaintiff or plaintiff's attorney "file with the complaint an affidavit of merit signed by a health professional." MCL 600.2912d(1) The affidavit is a qualified professional's opinion that the plaintiff has a valid malpractice claim. *Scarsella v Pollak*, 461 Mich 547, 548; 607 NW2d 711 (2000). As to the affidavit of merit and

complaint, a "plaintiff's theory in a medical malpractice case must be pleaded with specificity and the proofs must be limited in accordance with the theories pleaded." *Badalamenti*, 237 Mich App at 284.[11] Filing of a medical malpractice complaint without an affidavit of merit supporting its allegations is insufficient to commence an action and stop the running of the statute of limitations. *Scarsella, supra*.

Here, Plaintiff filed no affidavit of merit or complaint pleading her reliance on res ipsa loquitur. This is fatal to her assertion of the doctrine at trial. This issue has been addressed on at least two occasions. In *Dube v St. John Hosp. & Med. Ctr.*, Court of Appeals Docket No. 265887, *rel'd* May 16, 2006 (unpublished); 2006 WL 1329156 (**Exhibit P**), the Court of Appeals held that an affidavit of merit must be filed even if the theory is res ipsa loquitur. In *Dube*, the plaintiff filed an affidavit of merit signed by a board certified OB/GYN specialist. However, the plaintiff did not file an affidavit of merit as to her theory of res ipsa loquitur. The defendant moved for summary disposition on grounds the affidavit of merit did not comply with MCL 600.2912d(1), in part because of the failure to plead res ipsa loquitur. The court ruled:

> "While we accept and agree that the doctrine of res ipsa loquitur can apply in a medical malpractice action, we do not agree with plaintiff's assertion that, because expert testimony is not always necessary in a case based on the doctrine of res ipsa loquitur, an affidavit of merit was unnecessary in this case."

*Id* at *3. The court upheld the trial court's decision to dismiss the case where res ipsa loquitur was not pled in the affidavit of merit. In like fashion, Dr. Morris's affidavit of merit does not set

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[11] An affidavit of merit must contain a statement as to each of the following:

1. The claimed appropriate standard(s) of care;
2. How the standard of care was breached;
3. What conduct was required to comply with the standard of care; and
4. How the breach caused injury.

MCL 600.2912d(1).

forth or provide any notice that the plaintiff intended to argue res ipsa loquitur as a theory of liability. Nowhere does he, or, by extension, Plaintiff, suggest that the injury at issue does not occur absent any negligence.

In *Via*, *supra*, the Court of Appeals was asked to address whether a plaintiff could employ res ipsa loquitur in a medical malpractice case where it had not been pled. The plaintiff alleged that after a cardiac arrest in the hospital that required CPR and intubation, she suffered cuts to her esophagus. The doctors discovered and removed a small single-dose pill package from her esophagus after she stabilized. Plaintiff filed a complaint alleging the defendants were negligent in administering the pill that was packaged or by leaving the package in a place where plaintiff could swallow it. Defendants moved for summary disposition in part as to the second allegation that the pill was left in a place where plaintiff could swallow it was purely speculative. The trial court granted the motion. Plaintiff argued on appeal that she should have been allowed to proceed under a res ipsa loquitur theory. However, the Court of Appeals reasoned:

> "Plaintiff did not plead res ipsa loquitur in her complaint, and this failure, alone, is fatal to plaintiff's assertion of res ipsa loquitur because '[a] plaintiff's theory in a medical malpractice case must be pleaded with specificity and the proofs must be limited in accordance with the theories pleaded.'"

2014 WL 5364119 at *4, quoting *Badalamenti*, 237 Mich App at 284. The *Via* court upheld the trial court's dismissal. See also *Zdrojewski v Murphy*, 254 Mich App 50, 60-61; 657 NW2d 721 (2002).[12]

[12] "Defendants first argue that the trial court abused its discretion by granting Plaintiff's request to amend her complaint during trial to add a claim of res ipsa loquitur. Defendants claim that the trial court erred by applying MCR 2.118(C)(1) because Defendants did not consent to litigate Plaintiff's claim of res ipsa loquitur . . .

* * *

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The trial court's allowance of this unpled theory, resulting in an unwarranted jury instruction creating an inference of negligence, is also belied by the trial court's decision to enter an order during trial granting Defendants' motion to strike irrelevant expert standard of care criticisms "on unpled claims" (**Exhibit Q**, Order dated March 19, 2015). In that order, the trial court provided:

> "IT IS HEREBY ORDERED AND ADJUDGED that Plaintiff's claims and her expert's standard of care claims + testimony are limited to what has been pled in the complaint, more specifically whether Dr. Carpenter acted with the standard of care when he performed the August 3, 2010 right submandibular gland removal surgery.
>
> It is so Ordered."

*Id.* Since res ipsa loquitur was not pled, and its application was not even brought to the attention of the trial court until the morning of March 23, 2015 (Tr. 3/23/2015, pp 75-87), well after entry of the March 19, 2015 Order prohibiting unpled claims, res ipsa loquitur should have been disallowed.

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> [D]efendants did not object to the admission of evidence regarding res ipsa loquitur [and] [t]he trial court correctly reasoned that Subsection (C)(1) is the correct standard here because Defendants' failure to object to the admission of res ipsa loquitur evidence implied their consent to litigate the issue."

*Zdrojewski*, 254 Mich App at 60-61.

## RELIEF

WHEREFORE, Defendant-Appellant requests this Court reverse the Majority Opinion, adopt the Dissenting Opinion, instruct that the Judgment of No Cause of Action is reinstated, in the alternative reverse and remand to the Court of Appeals for consideration of issues other than the other acts issue and res ipsa loquitur issue, and in the second alternative reverse on the res ipsa loquitur ruling and remand to the trial court for further proceedings.

Respectfully submitted,

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Dated: October 25, 2016

STATE OF MICHIGAN

IN THE SUPREME COURT

PATRICIA MERCHAND,

Plaintiff-Appellee,

v

RICHARD L. CARPENTER, M.D.,

Defendant-Appellant,

and

MID-MICHIGAN EAR, NOSE, AND THROAT, P.C., a domestic professional service corporation, jointly and severally,

Defendant.

SC No. _____
COA No. 327272
LC No. 12-1343-NH
(Ingham Circuit Court)

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**PROOF OF SERVICE/STATEMENT REGARDING E-SERVICE**

STATE OF MICHIGAN )
)SS
COUNTY OF OAKLAND )

Monique M. Vanderhoff, being duly sworn, deposes and says that she is an employee of the law firm of Plunkett Cooney, and that on October 25, 2016, she caused to be served a copy of the Notice of Filing Application for Leave to Appeal, Application for Leave to Appeal, and Proof of Service/Statement Regarding E-Service upon:

**Counsel was e-served via TrueFiling**

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| | |
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| David R. Johnson (P33822)<br>Johnson & Wyngaarden<br>Attorneys for Defendant Mid-Michigan Ear Nose, and Throat, PC<br>3445 Woods Edge Drive<br>Okemos, MI 48864<br>drj@jwynlaw.com | **Counsel was e-served via the TrueFiling system** |
| Mark E. Fatum (P38292)<br>Patrick B. Ellis (P67879)<br>Rhoades McKee, PC<br>Trial Attorneys for Defendant-Appellant Richard L. Carpenter, M.D.<br>55 Campau Avenue, NW, Suite 300<br>Grand Rapids, MI 49503<br>mefatum@rhoadesmckee.com<br>pbellis@rhoadesmckee.com | **Counsel was e-served via the TrueFiling system** |

The undersigned further states that the *Notice of Filing Application* was served upon the following courts:

| | |
|---|---|
| Clerk of the Court<br>Ingham County Circuit Court<br>313 W. Kalamazoo<br>P.O. Box 40771<br>Lansing, MI 48901-7971 | **The trial court was served via U.S. Mail, all postage prepaid** |
| Michigan Court of Appeals | **Served via Court of Appeals' TrueFiling System** |

/s/Monique M. Vanderhoff
MONIQUE M. VANDERHOFF

Open.00400.50784.17578114-1

STATE OF MICHIGAN

IN THE SUPREME COURT

PATRICIA MERCHAND,

Plaintiff-Appellee,

v

RICHARD L. CARPENTER, M.D.,

Defendant-Appellant,

and

MID-MICHIGAN EAR, NOSE, AND THROAT, P.C., a domestic professional service corporation, jointly and severally,

Defendant.

SC No. _____
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LC No. 12-1343-NH
(Ingham Circuit Court)

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**INDEX OF EXHIBITS TO APPLICATION FOR LEAVE TO APPEAL**

| EXHIBIT LETTER | DESCRIPTION |
|---|---|
| **A** | August 2, 2016 Court of Appeals Majority Opinion |
| **B** | August 2, 2016 Court of Appeals Dissenting Opinion |
| **C** | September 14, 2016 Court of Appeals Order Denying Motion for Reconsideration |
| **D** | April 21, 2015 Judgment of No Cause of Action |
| **E** | Complaint and Affidavit of Merit |
| **F** | *Cetlinski v Brown, MD*, 91 Fed Appx 384 (CA 6, 2004) |
| **G** | *Groesbeck v Henry Ford Health System*, Court of Appeals Docket No. 307069, *rel'd* February 26, 2013 (unpublished); 2013 WL 951090 |
| **H** | *Via v Beaumont Health System*, Court of Appeals Docket No. 316776, *rel'd* October 21, 2014 (unpublished); 2014 WL 5364119 |
| **I** | *Pulley v The Gillette Co*, 1994 US Dist LEXIS 17659, *rel'd* October 13, 1994 (ED Mich 1994) (unpublished) |
| **J** | *Mattie v Sacred Heart Hospital*, 1992 WL 1071358 (Pa Com Pl, January 29, 1992) |

| EXHIBIT LETTER | DESCRIPTION |
|---|---|
| **K** | *Kuykendall v Dragun*, 2006 WL 728068 (Tex App-Eastland 2006) |
| **L** | *Hahn v USC University Hospital*, 2005 WL 1253907 (Cal App 2005) |
| **M** | *Lewis v Toledo Hospital*, 2004 WL 1368205 (Ohio App 2004) |
| **N** | *Au v Leung*, 2002 WL 1357099 (Cal App 2002) |
| **O** | Notice of Intent |
| **P** | *Dube v St. John Hosp. & Med. Ctr.*, Court of Appeals Docket No. 265887, *rel'd* May 16, 2006 (unpublished); 2006 WL 1329156 |
| **Q** | March 19, 2015 Order prohibiting unpled claims |

# EXHIBIT A

# STATE OF MICHIGAN

# COURT OF APPEALS

PATRICIA MERCHAND,

Plaintiff-Appellant/Cross-Appellee,

v

RICHARD L. CARPENTER, M.D.,

Defendant-Appellee/Cross-Appellant

and

MID-MICHIGAN EAR, NOSE, AND THROAT, P.C.,

Defendant.

UNPUBLISHED
August 2, 2016

No. 327272
Ingham Circuit Court
LC No. 12-001343-NH

Before: OWENS, P.J., and BORRELLO and O'BRIEN, JJ.

PER CURIAM.

In this medical malpractice case, plaintiff appeals as of right from a judgment of no cause of action in favor of defendant following a jury trial. For the reasons stated below, we reverse and remand for a new trial.

## I. FACTS

The underlying case arises from a medical malpractice action filed by plaintiff against defendant for a permanent injury to plaintiff's right hypoglossal nerve (HGN),[1] allegedly suffered during defendant's routine removal of plaintiff's right submandibular gland in August 2010.[2] Plaintiff suffered from sialadenitis, a salivary gland infection. Defendant, a board-

[1] The HGN is the 12th cranial nerve and controls movement of the tongue. There is a right and a left HGN, which provide motor activity to the right and left sides of the tongue.

[2] MMENT was dismissed from the lawsuit with prejudice by stipulation of the parties prior to trial.

certified otolaryngologist (an ear, nose, and throat doctor), used a harmonic scalpel, a surgical instrument that uses ultrasonic vibrations to simultaneously cut and cauterize tissue, to remove a stone from plaintiff's right salivary gland and a portion of the gland. According to defendant's records, the surgery lasted 23 minutes, there were no complications, and plaintiff's anatomy presented no anomalies. The pathology report on the excised portion of gland notes that the gland was inflamed, but was without infection.

Immediately after the anesthesia from the surgery wore off, plaintiff noticed that her tongue felt thick, that she was biting it all the time, and that a lot of saliva was coming from the right side of her mouth. She testified at trial that, prior to the surgery, she had experienced no problems with her tongue, with biting her tongue, or with saliva or spit coming from her mouth. Plaintiff and members of her family testified that, in the days and months following the surgery, plaintiff experienced tongue biting, difficulty swallowing and chewing, impaired speech, and spitting when talking. Plaintiff's daughter testified that plaintiff talked through "gritted teeth" in an effort not to bite her tongue, and would frequently exclaim "ow," and grab the side of her face.

Plaintiff testified at trial that she repeatedly told defendant about her tongue-biting and drooling symptoms at several follow-up visits over the next nine months, but defendant did not record her complaints in her medical record. Defendant's record of plaintiff's treatment charts some swelling and drainage, notes that defendant drained and cauterized plaintiff's incision and prescribed antibiotics, and states that plaintiff's incision is "healing nicely" and "doing well." Defendant testified that it was possible, but unlikely, that plaintiff informed him of post-operative complications. Plaintiff's last appointment with defendant was in March 2011.

In April 2012, plaintiff noticed that her tongue was deviating and that there were deep impressions in it. She contacted her primary care physician, who, after reviewing plaintiff's medical record and the results of an MRI, confirmed denervation of the right side of plaintiff's tongue. The physician referred plaintiff to an expert in neurology, who concluded that plaintiff's symptoms were consistent with an injury to plaintiff's HGN in August 2010.

At trial, Dr. Michael Morris, plaintiff's standard of care expert witness, explained that, in order to remove the submandibular gland, the surgeon makes an incision approximately four centimeters below the patient's jawbone, cutting through the skin, subcutaneous tissue, and muscle until reaching the connective tissue and obtaining a visual of the submandibular gland. As the surgeon elevates the submandibular gland, the muscles under the gland become visible. In those muscles are the HGN and the lingual nerve, nerves that supply the tongue with sensation and activity. Dr. Morris said that, when removing the submandibular gland, a surgeon has to identify those nerves to ensure preserving them. He opined that defendant breached the standard of care by failing to identify the HGN and by using the harmonic scalpel to separate the gland from the tissue in a way that brought the vibrating scalpel too close to the HGN.

Dr. Steven Schechter, a board-certified neurologist and clinical neurophysiologist testified to a reasonable degree of medical certainty that, based on the absence of symptoms prior to surgery, and the progression of symptoms following the surgery, plaintiff's nerve injury resulted from something that occurred during surgery. He explained that an injury to the HGN during surgery would not result in immediate, total paralysis of the tongue, and that deficits in

motor function would take months and years to develop. Dr. Schechter testified that the worsening of plaintiff's symptoms over time as reflected in the medical records was typical of an injury to the right HGN that occurred at the time of surgery.

Drs. Eugene Rontal and Henry Borovik, both board-certified ontolaryngologists, testified as expert witnesses on defendant's behalf. Both concluded that defendant did not injure plaintiff's HGN, reasoning that an injury to plaintiff's HGN during the August 2010 surgery would have produced immediate effects. Dr. Rontal said that the tongue deviation would have happened immediately and been obvious, and the tongue fasciculation, i.e., muscle twitching, that plaintiff currently experiences would have developed within three to four months of the injury. In like fashion, Dr. Borovik testified that, if defendant had injured plaintiff's HGN, there would have been an immediate loss of motor function.

After just over four hours of deliberation, the jury found defendant not professionally negligent by a vote of 6 to 2. After further proceedings not relevant to the instant appeal, the trial court entered a judgment of no cause of action in favor of defendant on April 21, 2015. Plaintiff appeals from the judgment, and defendant raises two issues on cross appeal.

## II. ISSUES ON APPEAL

On appeal, plaintiff raises a number of issues related to certain pretrial and trial rulings by the trial court prohibiting plaintiff's introduction of evidence from defendant's past medical malpractice cases, his 2012 termination from MMENT, and his 2013 arrest and prosecution in Florida for obtaining controlled substances without a valid prescription.

First, plaintiff contends that, because defendant presented himself as an expert, the trial court should have allowed her to cross-examine him under MRE 608(b) regarding past poor performances in order to attack his credibility. We disagree. We review the trial court's ruling regarding the admission of evidence for an abuse of discretion, *Craig v Oakwood Hosp*, 471 Mich 67, 76; 684 NW2d 296 (2004). The abuse of discretion standard recognizes "that there will be circumstances in which...there will be more than one reasonable and principled outcome." *People v. Babcock,* 469 Mich 247, 269; 666 NW2d 231 (2003). "An abuse of discretion occurs if the trial court's decision falls outside the range of principled outcomes." *Macomb Co Dep't of Human Services v Anderson*, 304 Mich App 750, 754; NW2d 408 (2014).

MRE 608(b) authorizes, for the purpose of attacking or supporting the witness's credibility, inquiry into specific instances of conduct under the following conditions:

> Specific instances of the conduct of a witness, for the purpose of attacking or supporting the witness' credibility, other than conviction of crime as provided in Rule 609, may not be proved by extrinsic evidence. They may, however, in the discretion of the court, if probative of truthfulness or untruthfulness, be inquired into on cross-examination of the witness (1) concerning the witness' character for truthfulness or untruthfulness, or (2) concerning the character for truthfulness or untruthfulness of another witness as to which character the witness being cross-examined has testified.

However, it is axiomatic that the mere fact that a physician has been sued for medical malpractice is not probative of his or her truthfulness, competency, or knowledge. *Heshelman v Lombardi*, 183 Mich App 72, 85; 454 NW2d 603 (1990). Physicians who testify as expert witnesses in medical malpractices cases may be questioned about their own past poor outcomes because such is relevant to the expert's competency and the weight to be given his or her testimony. *Wischmeyer v Schanz*, 449 Mich 469, 480; 536 NW2d 760 (1995). Even then, counsel cannot ask general questions about the number of times an expert witness has been sued for medical malpractice, *Persichini v William Beaumont Hosp*, 238 Mich App 626, 629; 607 NW2d 100 (1999), or questions about malpractice claims unrelated to the subject matter of the expert witness's testimony, *Wischmeyer*, 449 Mich at 482.

In the instant case, plaintiff cites no authority for her proposition that defendant should be subject to the same type of cross-examination to which witnesses that have been qualified as experts by the trial court are subject. Although plaintiff testified to his education, training, and experience, to how he generally performs a submandibular gland excision, and to how his usual practice compared with plaintiff's surgery, he did not seek qualification at trial as an expert, and the trial court explicitly stated that it would have denied such qualification had he sought it. The fact that defendant has been sued for medical malpractice in the past is not probative of his truthfulness, competency, or knowledge, *Heshelman*, 183 Mich App at 85, nor does it make it more or less likely that he committed malpractice in the instant case. Thus, any probative value in cross-examining defendant about past medical malpractice cases in an attempt to attack his credibility would have been substantially outweighed by prejudice arising from the danger that such questioning would lead the jury to conclude that defendant had a proclivity for committing malpractice. See *Wlosinski v Cohn*, 269 Mich App 303, 311-312; 713 NW2d 16 (2005). For these reasons, we conclude that the trial court did not abuse its discretion by prohibiting plaintiff from cross-examining defendant relative to prior medical malpractice cases under 608(b).

On more solid ground is plaintiff's contention that the trial court abused its discretion by prohibiting the testimony of Dr. Morris regarding the parallels between this case and records in plaintiff's past medical malpractices cases. It is not clear from the record under which rule of evidence plaintiff sought to admit Dr. Morris's testimony at trial. However, Plaintiff contends on appeal that the evidence was admissible under 404(b) to show defendant's scheme, plan, or system of creating medical records that did not accurately reflect his interactions with patients where surgeries resulted in serious complications. We agree.

MRE 404(b) applies equally in both civil and criminal cases, *Lewis v LeGrow*, 258 Mich App 175, 207; 670 NW2d 675 (2003), and provides in relevant part:

> Evidence of other crimes, wrongs, or acts is not admissible to prove the character of a person in order to show action in conformity therewith. It may, however, be admissible for other purposes, such as proof of motive, opportunity, intent, preparation, scheme, plan, or system in doing an act, knowledge, identity, or absence of mistake or accident when the same is material, whether such other crimes, wrongs, or acts are contemporaneous with, or prior or subsequent to the conduct at issue in the case. [MRE 404(b)(1).]

In *Lewis*, we provided a concise formulation of the elements that must be satisfied for other acts evidence to be admitted in a civil case; these elements were originally set forth by our Supreme Court in *People v VanderVliet*, 444 Mich 52, 508 NW2d 1114 (1993):

> (1) the evidence is offered for some purpose other than character to conduct, or a propensity theory; (2) the evidence is relevant (having any tendency to make the existence of a fact more or less probable) and material (relating to a fact of consequence to the trial); (3) the trial court determines under MRE 403 that the probative value of the evidence is not substantially outweighed by the danger of unfair prejudice; and (4) the trial court may provide a limiting instruction under MRE 105. [*Lewis*, 258 Mich App at 208, citing *Vandervliet*, 444 Mich at 74-75.]

A proper purpose is one other than one establishing defendant's character to show he acted in conformity therewith. *VanderVliet*, 444 Mich at 74.

In the instant case, plaintiff sought to cross-examine defendant at trial about his allegedly fictitious medical records in order attack his credibility pursuant to 608(b). Referring to defendant's testimony that it was possible but unlikely that plaintiff had informed him of her post-operative complaints, plaintiff sought to attack defendant's credibility with evidence that other patients with serious post-operative complaints also alleged that defendant had failed to chart their complaints. Although evidence from records of past medical malpractice cases is not admissible under 608(b), it is admissible under MRE 404(b) for a non-character purpose. *People v Sabin (After Remand)*, 463 Mich 43, 56; 614 NW2d 888 (2000) ("That our Rules of Evidence preclude the use of evidence for one purpose simply does not render the evidence inadmissible for other purposes."). Further, evidence admitted for a proper purpose under MRE 404(b) may be proved by extrinsic evidence. *People v Jackson (Mem)*, 475 Mich 909, 910; 717 NW2d 871 (2006).

The evidence plaintiff seeks to admit satisfies the *VanderVliet* factors as set forth in *Lewis*. First, it is proper to admit the other acts evidence at issue for the non-character purpose of showing that defendant has a "scheme, plan, or system in doing an act." MRE 404(b). Plaintiff contended below that she repeatedly told defendant about her tongue biting and excessive drooling following surgery and that defendant failed to chart her complaints. Rather, defendant told her that she was healing nicely and that the symptoms she was experiencing was a normal part of the healing process. Dr. Morris's review of other malpractice cases revealed the same pattern. At trial, defendant testified that it was possible that plaintiff told him about her tongue biting and excessive drooling, but unlikely. In addition, he said that he was not specifically aware of any other patients who complained that he did not chart their post-operative complaints, even though several people making just such allegations had brought actions against defendant for medical malpractice. The evidence of defendant's recordkeeping in past malpractice cases cannot be used to attack defendant's credibility or to show character or propensity, but it can be properly used to show that defendant followed a particular pattern when it came to cases with serious complications resulting from surgery.

Second, the other acts evidence is relevant and material. Evidence is relevant if has "any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." MRE 401. In the

instant case, the other acts evidence offered by plaintiff tends to show that defendant has a scheme, plan, or system of recordkeeping that severs any potential link between his surgery and the patient's post-operative complications by simply failing to chart them. If defendant's system is to omit mention of complications and patients' complaints to insulate himself from liability, this has the tendency of calling into question defendant's position that plaintiff's surgery and post-operative recovery were unremarkable, and supporting plaintiff's theory that the post-operative symptoms she experienced suggested an injury to her HGN.

Third, the probative value of the evidence is not substantially outweighed by unfair prejudice. MRE 403 requires the exclusion of relevant evidence only where its probative value is substantially outweighed by unfair prejudice. Unfair prejudice refers to the tendency that the jury will give undue or preemptive weight to the evidence. *Franzel v Kerr Mfg Co*, 234 Mich App 600, 618; 600 NW2d 66 (1999). Here, the other acts evidence has substantial probative value in showing that defendant has a scheme or plan when it comes to charting that minimized his exposure to liability by not recording patients' post-operative complaints. Arguing to the contrary, defendant asserts that the probative value of admitting the records under 404(b) is limited, given defendant's admission that he occasionally makes charting errors and the testimony at trial establishing that plaintiff experienced various post-operative complications. Admitting to occasional charting errors is one thing; having a "scheme, plan, or system" that insulates one from liability is another. Fairness and accuracy demands that the jury be presented with sufficient evidence to determine which it is. In addition, defendant always has the option of requesting an appropriate limiting instruction. MRE 105; *Lewis*, 258 Mich at 208.

Defendant contends that any error in the exclusion of evidence was harmless error because this case came down to a "battle of the experts," with plaintiff's expert opining that symptoms of an HGN injury are progressive, going from mild to severe, while defendant's experts insist that they are immediate. Defendant further contends that plaintiff's treatment records equally support the theories of both parties regarding whether HGN damage occurred during the surgery. However, defendant's record of plaintiff's treatment is silent regarding the tongue biting and drooling plaintiff experienced immediately after surgery. If such silence is due to the systematic omission of complications traceable to surgery, then excluding the other acts evidence was not harmless. Presented with evidence of such a system, the jury could reasonably have found it supported plaintiff's theory that her HGN was injured during surgery. The admission of the excluded evidence has significant probative value relative to a fair and accurate determination of whether defendant omitted plaintiff's post-operative symptoms because they were normal parts of the healing process, or because they were the type of complications from surgery that defendant systematically excludes from patients' records. Therefore, we conclude that substantial justice requires vacating the jury's verdict and remanding the matter to the trial court for a new trial. MCR 2.613 (A). In light of our disposition of this issue, we find it unnecessary to address plaintiff's remaining issues.

## III. ISSUES ON CROSS APPEAL

Defendant raises two issues on cross appeal.[3] First, he contends that the trial court abused its discretion by ruling that the evidence of defendant's alleged criminal conduct in Florida was admissible under MRE 608(b). Prior to trial, defendant filed a motion in limine to exclude evidence of defendant's arrest, prosecution, and plea agreement in Florida. The trial court ruled that the evidence at issue was not admissible under MRE 609, which addresses the circumstances in which evidence of a criminal conviction may be used to impeach a witness, because the incident did not lead to a conviction under Florida law.[4] The trial court further ruled that relevant evidence of the Florida conduct was admissible under 608(b). However, on the first day of trial, subsequent to argument from the parties, the trial court "added onto" its prior ruling, determining that the probative value of the evidence was substantially outweighed by the danger of unfair prejudice and concluding that it was inadmissible under MRE 403. On cross appeal, defendant raises the issue of the admissibility of the evidence under 608(b) as "an alternative ground to affirm" which we need address only if we disagree with plaintiff's "position on this point in the main appeal." Having not reached plaintiff's position on this point in the main appeal, we decline to address the issue in defendant's cross appeal.

Defendant also contends that the trial court erred by giving a res ipsa loquitur instruction. We disagree. We review for an abuse of discretion the trial court's ruling regarding whether a jury instruction is applicable to the facts of the case. *Swanson v Port Huron Hosp* (On Rem), 290 Mich App 167, 183; 800 NW2d 101 (2010).

The general rule in medical malpractices claims is:

> [T]here is no presumption of negligence from the mere failure of judgment on the part of a doctor in the diagnosis or in the treatment he has prescribed, or from the fact that he has been unsuccessful in effecting a remedy, or has failed to bring about as good a result as someone else might have accomplished, or even from the fact that aggravation follows his treatment." *Jones v Porretta*, 428 Mich 132, 151-152; 405 NW2d 863, 872 (1987).

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[3] For the sake of clarity, we will continue to use the terms "defendant" and "plaintiff" rather than "cross appellant" and "cross appellee" respectively.

[4] Under Florida law, when a defendant pleads *nolo contendere* and there is no adjudication of guilt, evidence of defendant's offense cannot be used to impeach defendant under Fla Stat 90.610, which is similar to MRE 609. *Dopson v State*, 719 So 2d 37, 38 (Fla Dist Ct App, 1998). "If the defendant successfully completes his probation he is not a convicted person but if the probation is violated the court may then adjudicate and sentence." *Thomas v State*, 356 So 2d 846, 847 (Fla Dist Ct App, 1978). In the instant case, not only did defendant obtain an order withholding adjudication, but prior to the start of trial, the Florida court sealed defendant's records pursuant to Fla Stat 943.059.

Nevertheless, in certain situations, the doctrine of res ipsa loquitur permits a plaintiff to establish a prima facie case for negligence with circumstantial evidence. *Id.* at 150-51. "The major purpose of the doctrine of res ipsa loquitur is to create at least an inference of negligence when the plaintiff is unable to prove the actual occurrence of a negligent act." *Id.*

In order to avail themselves of the res ipsa loquitur doctrine, plaintiffs must meet the following conditions:

> "(1) the event must be of a kind which ordinarily does not occur in the absence of someone's negligence;
>
> (2) it must be caused by an agency or instrumentality within the exclusive control of the defendant;
>
> (3) it must not have been due to any voluntary action or contribution on the part of the plaintiff"; and
>
> (4) "[e]vidence of the true explanation of the event must be more readily accessible to the defendant than to the plaintiff." [*Woodard v Custer*, 473 Mich 1, 7; 702 NW2d 522, 525 (2005), quoting *Jones*, 428 Mich at 150-151.]

That the injury complained of does not ordinarily occur in the absence of negligence either must be supported by expert testimony or be within the common understanding of the jury. *Locke v Pachtman*, 446 Mich 216, 231; 521 NW2d 786 (1994).

In the instant case, Dr. Morris stated his opinion that plaintiff's injury is an event that normally would not have happened absent defendant's negligence. He opined that, had defendant identified the HGN and used the scalpel on the gland and not the surrounding tissue, where the scalpel likely came too close to the nerve, the nerve would have been protected. Dr. Morris acknowledged under cross-examination that injury to the nerve is a recognized complication of the type of surgery plaintiff underwent, but explained that, under the particular circumstances of plaintiff's surgery, there is no reasonable explanation for the injury other than negligence:

> Because the – there wasn't a significant amount of disease in the gland. The outside surface was normal in appearance, according to the pathologist. There was [sic] no anatomical problems reported in the operative note as far as complications or anomalies or differences in Mrs. Merchand's neck that would have made injury to the nerve more likely.
>
> There wasn't excessive bleeding or other conditions during surgery that would have made the nerve more difficult to protect or to identify, so under the circumstances of her operation and her illness, damage to the hypoglossal nerve is not an accepted complication, and the risk of hypoglossal nerve as we – is very, very low, as a consequence.

Defendant contends that Dr. Morris's testimony that injury to the nerve is a recognized risk of submandibular gland excision of which he informs his patients is inconsistent with his

assertion that the subject event is of a kind that ordinarily would not occur absent negligence, and thus does not satisfy the first res ipsa loquitur requirement. However, the phrase, "the event," refers to more than just the fact of the injury, but encompasses the circumstances under which the injury occurred. See *Wilson v Stilwill*, 411 Mich 587, 608, 610; 309 NW2d 898 (1981) (implying that even in the cases of a known and accepted complication, such as a post-operative infection, the circumstances surrounding the complication may give rise to an inference of negligence). Accordingly, the essence of Dr. Morris's testimony is that given plaintiff's condition and the lack of complications or anomalies, injury to her nerve during surgery is an event that normally does not happen absent negligence.

Defendant also observes that, Dr. Morris admitted that infection could be another precipitating factor for HGN injury, but did not take into account the infection that plaintiff developed eight days after surgery. This claim ignores Dr. Morris's considerable testimony regarding evidence in defendant's records of infection, and his conclusion that infection was "[a]bsolutely not" the cause of injury to plaintiff's HGN. That Dr. Morris did not give the same weight as does defendant to whatever evidence existed of plaintiff's post-operative infection does not mean that he did not consider it.

Finally, defendant argues that the res ipsa loquitur instruction was unwarranted because plaintiff pointed to Dr. Morris's testimony and claimed that she had "direct evidence" of malpractice by defendant. Direct evidence is "[e]vidence that is based on personal knowledge or observation and that, if true, proves a fact without inference or presumption." *Black's Law Dictionary* (10th ed). Regardless of how plaintiff characterized Dr. Morris's testimony, it is undisputed that the only person in the operating room who observed and had knowledge of how defendant used the harmonic scalpel was defendant.

Plaintiff's theory was that defendant injured her HGN during surgery. Dr. Schechter testified that plaintiff's symptoms were consistent with an injury to the nerve that occurred at the time defendant removed her submandibular gland, and Dr. Morris testified that, given the circumstances of the surgery, the injury would not have occurred absent negligence. Defendant does not dispute that plaintiff presented evidence sufficient to show that the harmonic scalpel was in the exclusive control of defendant, that plaintiff did not contribute actively and voluntarily to her injury, and that the true explanation of plaintiff's injury is more readily accessible to defendant than to plaintiff. *Woodard*, 473 Mich at 7. The trial court's decision to instruct the jury on res ipsa loquitur is supported by published authority and the facts of the case. We conclude, therefore, that trial court did not abuse its discretion by determining that a res ipsa loquitur instruction was warranted.

We reverse and remand for a new trial. We do not retain jurisdiction.

/s/ Donald S. Owens
/s/ Stephen L. Borrello

# EXHIBIT B

# STATE OF MICHIGAN

# COURT OF APPEALS

PATRICIA MERCHAND,

Plaintiff-Appellant/Cross-Appellee,

v

RICHARD L. CARPENTER, M.D.,

Defendant-Appellee/Cross-Appellant

and

MID-MICHIGAN EAR, NOSE, AND THROAT, P.C.,

Defendant.

UNPUBLISHED
August 2, 2016

No. 327272
Ingham Circuit Court
LC No. 12-001343-NH

Before: OWENS, P.J., and BORRELLO and O'BRIEN, JJ.

O'BRIEN, J. (*dissenting*).

I respectfully dissent. This medical-malpractice lawsuit arises out of a surgery performed by defendant, Richard L. Carpenter, M.D., on plaintiff, Patricia Merchand, in 2010. Plaintiff alleges that defendant negligently injured her hypoglossal nerve (HGN) during the removal of her submandibular gland. Plaintiff presented expert testimony that supported her theory that defendant negligently injured plaintiff's HGN during the surgery. Defendant presented expert testimony that supported his theory that he was not negligent and that plaintiff's injuries were a known complication of the surgery. The jury heard this conflicting testimony and returned a verdict of no cause of action. On appeal, plaintiff claims that the trial court abused its discretion in excluding evidence regarding eight to ten other malpractice cases against defendant, in excluding evidence regarding defendant's alleged criminal activity in Florida two or more years after plaintiff's surgery, in excluding evidence regarding the termination of defendant's employment from Mid-Michigan Ear, Nose, and Throat, P.C., and a variety of other evidence in

hopes of impeaching defendant's credibility.[1] Because this evidence is irrelevant, more prejudicial than probative, and otherwise inadmissible, I would conclude that the trial court correctly excluded this evidence. Accordingly, I would affirm the jury's verdict of no cause of action.

## I. OTHER-ACTS EVIDENCE

On appeal, plaintiff argues, and the majority concludes, that the trial court abused its discretion in excluding the testimony of Dr. Michael Morris, who was qualified as an expert, regarding numerous other malpractice allegations against defendant.[2] I disagree with my colleagues' conclusion that "the testimony of Dr. Morris regarding the parallels between this case and records in plaintiff's past medical malpractice cases" "was admissible under [MRE] 404(b) to show defendant's scheme, plan, or system of creating medical records that did not accurately reflect his interactions with patients where surgeries resulted in serious complications" for several reasons.[3]

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[1] A trial court's decision whether to admit evidence is reviewed for an abuse of discretion. *Craig v Oakwood Hosp*, 471 Mich 67, 76; 684 NW2d 296 (2004). "At its core, an abuse of discretion standard acknowledges that there will be circumstances in which there will be no single correct outcome; rather, there will be more than one reasonable and principled outcome." *People v Babcock*, 469 Mich 247, 269; 666 NW2d 231 (2003). So long as "the trial court selects one of these principles outcomes, the trial court has not abused its discretion and, thus, it is proper for the reviewing court to defer to the trial court's judgment." *Id.* See also *Maldonado v Ford Motor Co*, 476 Mich 372, 388; 719 NW2d 809 (2006) (expressly adopting *Babcock*'s articulation of the abuse-of-discretion standard in civil cases).

[2] At the outset, it should be noted that I agree with my colleague's rejection of plaintiff's argument that defendant should have been subject to cross-examination as an expert even though he was not qualified as an expert and did not provide expert testimony. Plaintiff's claim that a new trial is required because "Defendant was paraded before the jury as an 'expert' surgeon" is not supported in fact or law. Additionally, plaintiff certainly could have objected to testimony regarding defendant's medical background but apparently chose not to. Nevertheless, because this specific conclusion had no bearing on the outcome of this appeal, my agreement in this regard is largely irrelevant.

[3] As the majority recognizes, "[i]t is not clear from the record under which rule of evidence plaintiff sought to admit Dr. Morris's testimony at trial." It should be made clear that plaintiff did *not* argue that Dr. Morris's testimony in this regard was admissible for system, plan, or scheme purposes before the trial court. At best, plaintiff merely referenced non-character purposes for admitting evidence in several briefs before the trial court, stating on more than one occasion as follows: "Evidence can be offered under MRE 404(b) for other purposes such as motive, opportunity, intent, preparation, scheme, plan or system in doing an act, knowledge, identity, or absence of mistake or accident when the same is material." Notably, these mere references were made only in relation to licensing and criminal allegations against defendant and *never* in relation to other malpractice allegations. In fact, plaintiff's response to defendant's

First, this testimony is irrelevant. *Lewis v LeGrow*, 258 Mich App 175, 208; 670 NW2d 675 (2003) (providing that character evidence is admissible for non-character purposes so long as it satisfies several requirements, one of which is that the evidence is relevant). " 'Relevant evidence' means evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." MRE 401. In concluding that Dr. Morris's testimony "regarding the parallels between this case and records in plaintiff's past medical malpractice cases" is relevant, my colleagues explain as follows:

> In the instant case, the other acts evidence offered by plaintiff tends to show that defendant has a scheme, plan, or system of recordkeeping that severs any potential link between his surgery and the patient's post-operative complications by failing to chart them. If defendant's system is to omit mention of complications and patients' complaints to insulate himself from liability, this has the tendency of calling into question defendant's position that plaintiff's surgery and post-operative recovery were unremarkable, and supporting plaintiff's theory that the post-operative symptoms she experienced suggested an injury to her HGN.

In my view, an expert's testimony regarding defendant's allegedly inaccurate recordkeeping does not have the tendency to make the existence of any fact that is of consequence to the determination of this action more probable or less probable than it would be without that testimony. Stated simply, defendant's recordkeeping is not at issue in this case.[4] Rather, it is his ability to perform what the majority describes as a "routine removal of plaintiff's right submandibular gland" that is at issue. Whether or not defendant negligently injured plaintiff's HGN in doing so is not made more or less probable based on his alleged recordkeeping deficiencies.[5] Had plaintiff, for example, pursued recovery under a theory that

motion in limine to exclude evidence regarding other malpractice allegations, including the attached brief, only references MRE 404(b) once, when she indicates that "[t]he court [in *Heshelman v Lambardi*, 183 Mich App 72, 82; 454 NW2d 603 (1990)] held that evidence of prior malfeasance by a witness is admissible only under very specific circumstances for a very specific reason pursuant to MRE 608(b) and MRE 404(b)." That is the *only* reference to MRE 404(b) with respect to the other malpractice allegations. Despite plaintiff's failure to make any cognizable argument under MRE 404(b) and the uncertainty as to which rule of evidence plaintiff sought to admit this testimony before the trial court, the majority nevertheless concludes that the trial court abused its discretion in excluding it under MRE 404(b), and I find such a conclusion troublesome.

[4] To be clear, plaintiff does not claim that defendant's failure to adequately record surgery complications or post-operative symptoms played any role in her injury. Her claim is clear—defendant negligently injured her HGN *during* the surgery at issue.

[5] The majority apparently acknowledges this lack of relevancy: "The fact that defendant has been sued for medical malpractice in the past . . . does not make it more or less likely that he committed malpractice in the instant case." While this conclusion was reached in reference to plaintiff's argument that defendant should be cross-examined as an expert without being qualified as an expert, I see no reason why the same conclusion does not apply with respect to

involved defendant's failure to properly recognize complications or properly address post-operative symptoms, my conclusion may well have been different. But, she did not. Rather, plaintiff's claim is straightforward—it is her position that defendant negligently injured her HGN *during* the surgery, and both parties presented conflicting evidence as to whether that was what actually occurred.[6]

Secondly, assuming arguendo, any relevancy is substantially outweighed by the danger of unfair prejudice. *Lewis*, 258 Mich App at 208 (providing that character evidence is admissible for non-character purposes so long as it satisfies several requirements, one of which is that the evidence is not unfairly prejudicial). "Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." MRE 403. In concluding that Dr. Morris's testimony "regarding the parallels between this case and records in plaintiff's past medical malpractice cases" was not unfairly prejudicial, my colleagues explain as follows:

> Here, the other acts evidence has substantial probative value in showing that defendant has a scheme or plan when it comes to charting that minimized his exposure to liability by not recording patients' post-operative complaints. Arguing to the contrary, defendant asserts that the probative value of admitting the records under [MRE] 404(b) is limited, given defendant's admission that he occasionally makes charting errors and the testimony at trial establishing that plaintiff experienced various post-operative complications. Admitting to occasional charting errors is one thing; having a "scheme, plan, or system" that insulates one from liability is another. Fairness and accuracy demands that the jury be presented with sufficient evidence to determine which it is. In addition, defendant always has the option of requesting an appropriate limiting instruction. MRE 105; *Lewis*, 258 Mich at 208.

It is my belief that any probative value of Dr. Morris's testimony as to the existence of any fact of consequence to the determination of this action was substantially outweighed by the danger of unfair prejudice in allowing an expert to testify regarding a variety of other allegations of malpractice against defendant. As an example, plaintiff sought to admit Dr. Morris's

the majority's relevancy analysis under MRE 404(b). The fact that these malpractice cases also allegedly reflect similar recordkeeping tendencies does not, in my view, render them any more relevant than they ordinarily are.

[6] Importantly, we should not overlook the fact that plaintiff was permitted to present a substantial amount of testimony portraying defendant's recordkeeping practices in this case as insufficient. Plaintiff testified that she informed defendant of a variety of complications and post-operative symptoms that were not adequately recorded, and experts, both plaintiff's and defendant's, opined that defendant's recordkeeping lacked sufficient detail. Even defendant admitted that he possibly failed to record various complaints made by plaintiff. Frankly, plaintiff's position that defendant inadequately failed to record her complications and post-operative symptoms was made clear to the jury. Whether the jury found it credible was a determination for the jury, not this Court, to make.

testimony regarding a malpractice case in which defendant's nasal surgery allegedly resulted in blindness. It is unclear how the admission of this evidence would make the allegation that defendant negligently injured plaintiff's HGN during the surgery at issue more or less probable, but it is certainly clear that it would unfairly prejudice the jury against defendant. Furthermore, as defendant correctly recognizes, the admission of this evidence would require him to defend numerous malpractice allegations, all of which have nothing to do with what is at issue here—the issue of whether defendant negligently injured plaintiff's HGN during surgery.

Finally, I believe the majority has overstated the value of Dr. Morris's testimony in this regard. The following is the testimony, *in its entirety*,[7] that plaintiff sought to admit:

> *Q*. Doctor Morris, just so you know what we're doing right now, we're creating a separate record on some issues that were not addressed in front of the jury.
>
> Doctor Morris, have you had an occasion to become familiar with other patient care rendered by Richard Carpenter other than this case?
>
> *A*. Yes.
>
> *Q*. Tell me about how you've become aware of that.
>
> *A*. Through the process of being asked to review and reviewing other cases that were presented to me for review who were cared for by Doctor Carpenter.
>
> *Q*. Ju[s]t approximately how many cases have you reviewed involving Richard Carpenter's treatment of patients?
>
> *A*. Eight or 10.
>
> *Q*. And have any of those involved nerve injuries?
>
> *A*. Yes.
>
> *Q*. Just approximately how many of those?
>
> *A*. Two or three others.

[7] This is the entirety of the testimony that plaintiff admitted in a special record for purposes of appellate review. Had plaintiff intended to introduce additionally testimony or evidence regarding these other malpractice cases, I am unable to find any indication as to what that evidence might have been in the record. Surely it is plaintiff's, not this Court's, burden to identify that testimony and evidence.

*Q*. Okay. What type of nerve injury cases have you had a chance to review?

*A*. Nerve injuries of the neck, recurrent neck injuries, marginal mandibular nerve injuries. That's all I can think of.

*Q*. In one of those cases did it actually involve a submandibular gland and tumor removal surgery?

*A*. Yes.

*Q*. And in respect to all the different cases that you have reviewed concerning Richard Carpenter and the separate reports and office records, do you have any particular insight concerning his operative reports?

*A*. Yes.

*Q*. What is that, please?

*A*. That the operative report doesn't characterize any problem occurring during the surgery even if there's a complication that's significant.

*Q*. Is that information frequently left out of his operative reports?

*A*. Yes.

*Q*. How about with respect to his office records. Based on reviewing charts from, you know, many, many of his patients, do you have any observations concerning how he maintains his . . . charting in his office records for patient complaints?

*A*. Yes.

*Q*. What is that?

*A*. That what the patients complain about to him isn't recorded but they may see another doctor in his practice the next day or the next week and the other doctor records that information that had to be present on the day they saw Doctor Carpenter.

*Q*. Okay. And have you also gained any familiarity concerning just, you know, how meticulous Richard Carpenter's dissections are during surgeries?

*A*. Yes.

*Q*. What is the information you have learned?

*A*. That during some of his surgeries, operation on one part of the nose led to problems in another part of the nose that wasn't even involved with the

surgery, or an operation in those ended up causing blindness in a patient. That wasn't part of the nasal surgery. Or operations on the thyroid gland, removed the wrong side of the gland was another case.

*Q*. Was that what you would describe as meticulous dissection?

*A*. No.

*Q*. Is that what would call careful attention to the details of the operation of the acts performed in the surgery?

*A*. No.

The absence of that testimony, alone, is what the majority claims requires a new trial in this matter. I strongly disagree. First, the final four questions of this examination, i.e., the questions regarding "how meticulous Richard Carpenter's dissections are during surgeries," the details of the injuries allegedly sustained during those surgeries, and whether Dr. Morris "would call [it] careful attention to the details of the operation of the acts performed in the surgery" *have absolutely, unequivocally nothing to do with a system, plan, or scheme in recordkeeping*. Furthermore, none of the testimony quoted above reflect what the majority, in apparently adopting plaintiff's theory, labels as "a 'scheme, plan, or system' that insulates one from liability[.]" Rather, it reflects Dr. Morris's opinion about the adequacy of defendant's recordkeeping. Additionally, and perhaps most importantly, allowing the admission of this testimony by Dr. Morris, who testified as an expert, requires and opens the door to an incredible amount of other evidence regarding these surgeries as well as all other surgeries performed by defendant that reflect on his recordkeeping.

If this evidence is admitted, it is my view that defendant will obviously be able to offer evidence in response to Dr. Morris's testimony in this regard. Specifically, if testimony regarding defendant's recordkeeping during somewhere between eight and ten surgeries that allegedly resulted in malpractice is admissible, I would assume that testimony regarding defendant's recordkeeping during all other surgeries that did not result in malpractice allegations would also be admissible to refute the notion that his recordkeeping is faulty only in surgeries in which he wishes to cover up his own negligence. Further, I would assume someone, other than Dr. Morris who apparently reviewed these records at plaintiff's counsel's request, will have to lay foundation as to their accuracy. In reviewing the record, I am left with no indication nor evidence as to whether these other patients made or did not make the complaints that Dr. Morris opines they would have. Additionally, based on the record, I discern no admissible evidence as to whether any of those other patients' injuries actually resulted from defendant's negligence. Presumably, defendant will be able to challenge that with his own expert testimony, and I agree with the trial court's conclusion that the admission of both parties' attempts to prove or disprove these other medical malpractice allegations would be "highly prejudicial" and deny defendant any chance at "a fair trial." Ultimately, it is my view that these other surgeries and malpractice allegations by Dr. Morris have no bearing on the issue of whether defendant was negligent in this

case. While I readily admit that witness credibility is always at issue, it cannot be disputed that all character evidence, especially irrelevant character evidence, impacts a witness's credibility.[8] That does not, however, render it automatically admissible.

Accordingly, I would conclude that the trial court did not abuse its discretion in excluding "the testimony of Dr. Morris regarding the parallels between this case and records in plaintiff's past medical malpractice cases" under MRE 404(b). Indeed, as we have held before, "close evidentiary question[s] ordinarily cannot be an abuse of discretion," *Lewis*, 258 Mich App at 200, and the evidentiary question in this case, at a minimum, was close. Based on that conclusion, I would affirm the jury's verdict of no cause of action.[9]

Although not addressed by the majority, my conclusion renders it necessary to briefly address other evidentiary challenges made by plaintiff before the trial court and again on

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[8] Notably, the majority clearly concludes that "[t]he evidence of defendant's recordkeeping in past malpractice cases cannot be used to attack defendant's credibility . . . ." If Dr. Morris's testimony in this regard is not being admitted to negatively impact defendant's credibility, it is very difficult for me to ascertain what relevancy it has.

[9] While unnecessary in light of my conclusion with respect to MRE 404(b), I would also note that this testimony could have been excluded under MRE 608(b) as well. It appears undisputed that the evidence at issue constituted character evidence, MRE 608(a), and MRE 608(b) unequivocally prevents the admission of that type of extrinsic evidence:

> Specific instances of the conduct of a witness, for the purpose of attacking or supporting the witness' credibility, other than conviction of a crime as provided in Rule 609, may not be proved by extrinsic evidence. They may, however, in the discretion of the court, if probative of truthfulness or untruthfulness, be inquired into on cross-examination of the witness (1) concerning the witness' character for truthfulness or untruthfulness, or (2) concerning the character for truthfulness or untruthfulness of another witness as to which character the witness being cross-examined has testified.
>
> The giving of testimony, whether by an accused or by another other witness, does not operate as a waiver of the accused's or the witness' privilege against self-incrimination when examined with respect to matters which relate only to credibility.

Dr. Morris's testimony is unequivocally extrinsic evidence offered to attack defendant's character. Thus, it is inadmissible under MRE 608(b). While cross-examination may, but is not required to, be permitted in this regard, Dr. Morris's testimony is simply inadmissible extrinsic evidence. Nevertheless, assuming that his testimony was admissible under MRE 608, it remained subject to MRE 402 and MRE 403, and, as stated above, both rules prevent its admission.

appeal.[10] Plaintiff claims that defendant's "claimed disabilities, both physical and mental,"[11] "evidence of Defendant's former partners . . . who fired him for reasons including Defendant's lack of trustworthiness,"[12] and evidence regarding 2012 criminal allegations against defendant in Florida should have been presented to the jury[13]. In support of these claims, plaintiff states as follows: "Under MRE 608(b), evidence of specific instances of conduct is admissible if probative of truthfulness or untruthfulness." That is simply untrue. In fact, MRE 608(b) provides, in pertinent part, *the exact opposite*: "Specific instances of the conduct of a witness, for the purpose of attacking or supporting the witness' credibility, other than conviction of crime as provided in Rule 609, may *not* be proved by extrinsic evidence." (Emphasis added.) While that subsection does provide that cross-examination *may* be permitted in this regard, it is within the trial court's discretion and subject to MRE 402 and MRE 403. And, for similar reasons as those stated with respect to MRE 404(b) above, the trial court's decision to exclude this evidence did not constitute an abuse of discretion.[14]

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[10] It should be noted that the type of evidence that plaintiff wishes to admit in this regard is completely unclear. As this is not addressed by the majority, it is not clear how it will be handled on remand.

[11] Plaintiff alleged before the trial court that defendant suffered from a mental disability based only upon his deposition testimony. Nothing else in the record supports this allegation, and plaintiff has not made any assertion that this alleged mental disability existed at the time of the surgery in this case. Rather, as with the other evidence discussed on appeal, plaintiff simply sought to admit this evidence in hopes that it would render defendant's testimony less credible.

[12] Plaintiff claims that "Defendant's former partners at [Mid-Michigan Ear, Nose, and Throat, P.C.] fired him for reasons including Defendant's lack of trustworthiness." This lack of trustworthiness apparently arose from defendant's violation of a recently implemented office policy, what plaintiff's counsel describes as "billing irregularities," and other reasons. It was plaintiff's position that this evidence was admissible because defendant "opened the door" by testifying without objection that he served as Mid-Michigan Ear, Nose, and Throat, P.C.'s president in the past.

[13] Plaintiff describes this 2012 alleged criminal activity, which allegedly occurred two years after the surgery at issue in this case and was resolved by a nolo contendere plea, as "obtaining narcotics by fraud." Even she admits, however, that "there is no similarity between the facts underlying Defendant's obtaining narcotics by fraud and the medical malpractice at bar." Nevertheless, she claims that we can assume "that Defendant had been abusing prescription narcotics for quite some time" and that this "chronic abuse of narcotics may have had an effect on his ability to perform Plaintiff's surgery." This is an assumption I am not willing to make based on plaintiff's unsupported and self-serving hypotheses. Plaintiff has not alleged that defendant was intoxicated, in any manner, during plaintiff's surgery.

[14] Plaintiff's position is simple, and is one that this Court and our Supreme Court have rejected time and time again. Her position is that a variety of evidence against defendant, i.e., "evidence concerning . . . the underlying facts of a criminal prosecution for obtaining prescription narcotics by fraud, evidence concerning the fact that a reason he was discharged from his medical practice

## II. RES IPSA LOQUITUR INSTRUCTION

I also disagree with my colleague's conclusion that the trial court did not abuse its discretion in instructing the jury on res ipsa loquitur. This Court has unequivocally held that a res ipsa loquitur instruction is improper when the type of injury sustained is a known complication of the medical procedure at issue and can occur without any negligence on behalf of the treating physician. *Swanson v Port Huron Hosp (On Remand)*, 290 Mich App 167, 185; 800 NW2d 101 (2010) ("Since this type of injury is a known complication of laparoscopic surgery, and since this type of injury can occur without any negligence on the part of the treating physician, it is axiomatic that instructing the jury on the doctrine of res ipsa loquitur was an abuse of discretion."). Here, both plaintiff's and defendant's experts testified that nerve injury is a known complication of submandibular gland excision and could occur without any negligence on behalf of the treating physician.[15] While it is true, as plaintiff and the majority point out, that the experts disagree as to whether it was defendant's negligence that caused the injury in this case, that, alone, is insufficient to support a res ipsa loquitur instruction.

My colleagues rely on *Wilson v Stilwill*, 411 Mich 587, 608; 309 Mich NW2d 898 (1981), for the "impl[ication] that even in the cases of a known and accepted complication, such as a post-operative infection, the circumstances surrounding the complication may give rise to an inference of negligence." I cannot agree with that understanding of *Wilson*. In my view, *Wilson* compels the opposite understanding. As the Supreme Court stated in that case, "The mere occurrence of a post-operative infection is not a situation which gives rise to an inference of negligence when no more has been shown than the facts that an infection has occurred and that an infection is rare." *Id.* In this case, like in *Wilson*, plaintiff has shown only that an injury

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was that the other physicians were unable to trust him, and evidence of his other botched surgeries on other patients," should be admissible to present "an accurate and fair picture of Defendant to the jury[.]" It cannot be disputed that this evidence is character evidence, see generally MRE 404, and this evidence has absolutely no bearing on the jury's determination as to whether defendant negligently injured plaintiff's HGN while removing her submandibular gland. Moreover, extrinsic evidence of specific instances of conduct is not admissible under MRE 608(b), and that is precisely the type of extrinsic evidence that defendant seeks to admit.

[15] Specifically, Dr. Morris, plaintiff's standard-of-care expert, testified as follows:

> *Q.* Okay. So everybody remembers [because this question was originally objected to], injury to those nerves, lingual nerve, hypoglossal nerve, marginal mandibular branch, are all recognized complications of a submandibular gland excision surgery, true?
>
> *A.* True.

While Dr. Morris also opined that plaintiff's injury would not have occurred but for defendant's negligence in this case, I cannot ignore the fact that he admitted that it was a "recognized complication[.]"

occurred and that such an injury is rare absent negligence on behalf of the treating physician. Thus, as in *Wilson*, "plaintiffs have not met the threshold requirement for an inference of negligence[.]" *Id.*

Accordingly, I would conclude that the trial court abused its discretion in instructing the jury on res ipsa loquitur. However, in light of the jury's verdict, this instructional error was harmless.

/s/ Colleen A. O'Brien

# EXHIBIT C

# Court of Appeals, State of Michigan

## ORDER

Patricia Merchand v Richard L. Carpenter MD

Docket No. 327272

LC No. 12-001343-NH

Donald S. Owens
Presiding Judge

Stephen L. Borrello

Colleen A. O'Brien
Judges

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The Court orders that the motion for reconsideration is DENIED.

O'Brien, J., would grant motion for reconsideration.

A true copy entered and certified by Jerome W. Zimmer Jr., Chief Clerk, on

SEP 14 2016

Date

Chief Clerk

# EXHIBIT D

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF INGHAM

PATRICIA MERCHAND,

Plaintiff,

vs. File No. 12-1343-NH

RICHARD L. CARPENTER MD, Hon. Rosemarie E. Aquilina

Defendant.

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JUDGMENT OF NO CAUSE OF ACTION

This matter having come before this Honorable Court for jury trial, March 16, 2015 through March 27, 2015, and the jury having deliberated and returned a verdict of no negligence in favor of Richard L. Carpenter MD,

IT IS HEREBY ORDERED AND ADJUDGED that a judgment of no cause of action is hereby entered in favor of Richard L. Carpenter MD.

IT IS SO ORDERED.

Dated: 21 April 15

JUDGE ROSEMARIE E. AQUILINA

Hon. Rosemarie E. Aquilina P37670

Approved as to form and notice of presentment and entry waived:

See attached

Kitty L. Groh (P36722)
Attorney for Plaintiffs

Mark E. Fatum (P38292)
Patrick B. Ellis (P67879)
Attorney for Defendant Dr. Carpenter



U:\46\46005\282\PLD\JUDGMENT (stipulated) 4-15-15.doc v/b

IT IS HEREBY ORDERED AND ADJUDGED that a judgment of no cause of action is hereby entered in favor of Richard L. Carpenter MD.

IT IS SO ORDERED.

Dated: .....

Hon. Rosemarie E. Aquilina

Approved as to form and notice of presentment and entry waived:

Kitty L. Groh (P36722)
Attorney for Plaintiffs

Mark E. Fatum (P38292)
Patrick B. Ellis (P67879)
Attorney for Defendant Dr. Carpenter

# EXHIBIT E

**STATE OF MICHIGAN**
**INGHAM COUNTY CIRCUIT COURT**

PATRICIA MERCHAND,

Plaintiff,

v

RICHARD CARPENTER, M.D., and MID-MICHIGAN EAR, NOSE AND THROAT, P.C., a domestic professional service corporation, jointly and severally,

Defendants.

File No. 12- 1343 -NH

Hon. [illegible]

Kitty L. Groh (P36722)
Farhat & Story, P.C.
Attorneys for Plaintiff
1003 North Washington Avenue
Lansing, MI 48906-4868
(517) 351-3700

**COMPLAINT**

*There is no other pending or resolved civil action arising out of the same transaction or occurrence as alleged in the Complaint.*

NOW COMES Plaintiff, Patricia Merchand, by and through her attorneys, Farhat & Story, P.C., for her cause of action against these Defendants states as follows:

1. At all times pertinent hereto, Plaintiff Patricia Merchand was resident of the county of Clinton, state of Michigan.

2. All of the actions and activities by Defendants, as herein alleged, occurred within the confines of the county of Ingham, state of Michigan.

3. At all times pertinent hereto, Defendant Mid-Michigan Ear, Nose and Throat, P.C., was a domestic professional service corporation existing under the laws of the state of Michigan, and operated a medical practice in the city of East Lansing, county of Ingham, state of Michigan for the care and treatment of the public, including Plaintiff Patricia Merchand.

4. At all times pertinent hereto, Defendant Mid-Michigan Ear, Nose and Throat, P.C., employed and/or engaged the services of physicians, medical and non-medical personnel who acted as agents and employees, and/or apparent or ostensible agents and/or agents by estoppel of Defendant Mid-Michigan Ear, Nose and Throat, P.C., sometimes acting in their capacities as agents and employees and/or apparent or ostensible agents or agents by estoppel of Mid-Michigan Ear, Nose and Throat, P.C., and, at other times herein described, acting as agents and employees of the individual Defendants herein.

5. At all times pertinent hereto, Defendant Richard Carpenter, M.D. (hereinafter referred to as "Defendant Carpenter"), was a physician specializing in otolaryngology, licensed to practice in the state of Michigan, and at all times pertinent hereto, was specializing in the practice of otolaryngology and held himself out to be a specialist in otolaryngology in the county of Ingham, state of Michigan. The website of Defendant Mid-Michigan Ear, Nose and Throat, P.C. states that Defendant Carpenter is a board-certified otolaryngologist. The Sparrow Hospital website states Defendant Carpenter is a board-certified otolaryngologist. The American Board of Medical Specialties states that Defendant Carpenter was a board-certified otolaryngologist.

6. At all times pertinent hereto, the specialty engaged in by Defendant Carpenter was otolaryngology, and he held himself out as a specialist in otolaryngology and acted in that capacity when he was negligent in providing care and treatment to Patricia Merchand.



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7. At all times pertinent hereto, Defendant Carpenter was an employee, agent or servant, and/or apparent or ostensible agent or agent by estoppel of Defendant Mid-Michigan Ear, Nose and Throat, P.C.

8. Patricia Merchand was not negligent in any manner.

9. Plaintiff has provided Defendants with all required statutory notice and required Notice of Claim, pursuant to MCL 600.2912b, and notarized Affidavit of Meritorious Claim of Michael S. Morris, M.D., F.A.C.S., is attached as Exhibit A.

10. More than 154 days have elapsed from the date Defendants were served with a Notice of Intent. Defendant has not provided Plaintiff a written response to her Notice of Intent.

11. Dr. Morris is a board-certified otolaryngologist.

12. Dr. Morris's affidavit complies with MCL 600.2912d, and sets forth that he has reviewed the Notice of Intent and all of the medical records supplied to him.

13. Dr. Morris' affidavit sets forth the applicable standard of care and the actions that should have been taken or omitted by Defendant Carpenter to comply with the applicable standard of care.

14. Dr. Morris' affidavit sets forth his opinion that the applicable standard of care was breached.

15. Dr. Morris' affidavit sets forth the manner in which the breach of the standard of care was the proximate cause of the injury.

16. Attached to this Complaint as Exhibit B is the affidavit of Plaintiff's counsel stating that she reasonably believes Dr. Morris' qualifications meet the requirements of an expert witness under MCL 600.2169 and MCL 600.2912d.

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17. The amount in controversy, exclusive of interest, costs and attorney fees, exceeds Twenty-five Thousand Dollars ($25,000).

**COUNT I**

**Defendant Carpenter**

18. On or about June 28, 2010, Patricia Merchand sought care and treatment from Defendant Mid-Michigan Ear, Nose and Throat, P.C., for swelling in the right submandibular area.

19. Defendant Mid-Michigan Ear, Nose and Throat, P.C., provided Defendant Carpenter for the care and treatment of Patricia Merchand.

20. Defendant Carpenter noted in his office record for June 28, 2010, that Plaintiff had a history of swelling in the right submandibular area for about a month on and off. He further noted that she had no real pain. Defendant Carpenter noted that his evaluation of the salivary glands did not reveal any abnormalities.

21. Defendant Carpenter's record for Plaintiff states his impression was intermittent right sialadenitis in the submandibular area. Defendant Carpenter ordered a CT scan and Keflex 500 mg QID and fluids.

22. On or about June 30, 2010, Plaintiff underwent a CT of the neck which was reported as revealing mild right submandibular gland swelling consistent with sialadenitis. No evidence of a neck mass adenopathy or sialolith in Wharton's Duct on the right was identified.

23. On July 12, 2010, Defendant Carpenter evaluated Plaintiff and he stated in his record that she had a history of chronic sialadenitis of the right submandibular gland that had been

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present for four months. Defendant Carpenter noted in his record that Plaintiff had been on Keflex several times.

24. On July 12, 2010, Defendant Carpenter advised Plaintiff that she had multiple stones of the right submandibular gland and recommended that she undergo surgery to remove the gland.

25. Defendant Carpenter never advised Plaintiff that there were other less invasive treatments or surgical options.

26. Defendant Carpenter did not obtain adequate pre-operative consent including advising Plaintiff of the risks of surgery and the alternatives to surgery.

27. Defendant Carpenter scheduled Plaintiff to undergo surgery on August 3, 2010.

28. On July 19, 2010, Plaintiff underwent a manual extraction of one stone of the submandibular gland by Martin Tuck, D.D.S.

29. Prior to surgery on August 3, 2010, Plaintiff advised Defendant Carpenter that Martin Tuck manually extracted a stone from the right submandibular gland. Defendant Carpenter elected to proceed with the surgery on August 3, 2010.

30. Defendant Carpenter dictated the history and physical for the August 3, 2010 scheduled surgery at Sparrow Hospital and stated that the swelling of the right submandibular vein had been present for about three months and that she had no real pain. Defendant Carpenter stated that Plaintiff had a mass of the right submandibular vein.

31. At all times pertinent hereto, Plaintiff did not have a mass of the right submandibular gland or vein.

32. On August 3, 2010, Defendant Carpenter, according to his Operative Report, performed excision of the right submandibular gland. In his Operative Report Defendant



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Carpenter stated that Plaintiff had recurrent sialadenitis and stones, which have been removed in the office. Defendant Carpenter stated in his operative note that Plaintiff continued to have stones and swelling, pain and pressure which were not responding to antibiotic therapy.

33. Defendant Carpenter in his operative notes states he identified the right submandibular branch of the nerves of the face and tongue and retracted it superiorly.

34. Defendant Carpenter in his Operative Report stated that he removed the submandibular gland, a stone and duct. Defendant Carpenter noted that there was a stone extruded through the duct and that it was removed.

35. During the surgery performed by Defendant Carpenter he did not identify or remove a stone from the submandibular gland, duct or any other location.

36. Defendant Carpenter in performing the surgery on August 3, 2010, did not properly identify and inspect the anatomy and landmarks including, but not limited to, the neurological anatomy, the anatomy and nerves for the submandibular space, the motor and sensory nerves of the mouth and tongue, the hypoglossal nerve, the lingual nerve and the para and sympathetic nerves.

37. Defendant Carpenter in performing surgery on August 3, 2010, did not properly identify, locate and protect the neurologic anatomy to the face, mouth and tongue including, but not limited to, the submandibular space, motor and sensory nerves, the para and sympathetic nerves, the marginal mandibular branch nerves, the lingual nerve and the hypoglossal nerve.

38. During the surgery performed by Defendant Carpenter, he negligently and improperly performed surgery on Plaintiff and failed to identify, inspect, locate, visualize and protect the neurologic anatomy and the nerves to the face, mouth and tongue and submandibular

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space, motor and sensory nerves, the para and sympathetic nerves, the lingual nerves and the marginal mandibular branch nerves including, but not limited to, the hypoglossal nerve.

39. On August 3, 2010, Defendant Carpenter was negligent in performing surgery and negligently injured the nerves to the mouth and face and the hypoglossal nerve and he stretched, kinked, bruised, cut, tore, crushed, compressed, transected, burned or otherwise injured the nerves.

40. Defendant Carpenter in performing surgery on August 3, 2010, did not properly inspect the operative field, the neurologic anatomy, the submandibular space and the nerves which supply the mouth and tongue, the motor and sensory nerves, the marginal mandibular branch nerves, the hypoglossal nerve and the lingual nerve.

41. Prior to the conclusion of surgery on August 3, 2010, Defendant Carpenter failed to identify and diagnose that he injured the neurologic anatomy and the nerves to the face, mouth and tongue during surgery including, but not limited to, the hypoglossal nerve and he failed to repair the injuries to the nerves including, but not limited to, the hypoglossal anatomy and he failed to make arrangements for another surgeon to repair the injured neurologic anatomy to the mouth and tongue including the hypoglossal nerve.

42. Defendant Carpenter submitted the surgical specimen which he described as the right submandibular gland and a stone to the pathology department at Sparrow Hospital.

43. The pathologist, who reviewed the surgical specimen submitted by Defendant Carpenter for the surgery he performed on Plaintiff on August 3, 2010, reported that the specimen did not contain any calculi, masses, nodules, lesions or stones.

44. Contrary to Defendant Carpenter's statement in his operative note, Plaintiff did not have any stones and he never removed any stones from her submandibular gland or duct.



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45. Defendant Carpenter never advised Plaintiff that she did not have any stones and that he did not remove any stones during the August 3, 2010 surgery.

46. On August 3, 2010, Dr. Carpenter wrote Patricia Merchand a prescription for Keflex.

47. Following the surgery, Patricia Merchand developed severe swelling of her neck to the extent that she felt her incision was going to rip open. Patricia Merchand left a message for Dr. Carpenter on or about August 11, 2010, advising him of the severe swelling.

48. Patricia Merchand received a return call from Dr. Carpenter's office and was advised that she could experience swelling of her neck for up to two years. Dr. Carpenter wrote a prescription for Keflex.

49. The swelling of the neck continued to increase and on or about August 14, 2010, the surgical incision on her neck burst open. Patricia Merchand contacted Dr. Carpenter's office, Mid-Michigan Ear, Nose and Throat, P.C. The on-call physician, Dr. Richardson, contacted her and advised her to take it easy and to present to the office the following Monday 8/16/10 to see Dr. Carpenter.

50. On or about August 15, 2010, Patricia Merchand's condition and infection worsened. Patricia Merchand again called Mid-Michigan Ear, Nose and Throat, P.C. She spoke to Dr. Richardson and advised him that she was worse and the surgical wound was infected. Dr. Richardson again instructed her to take it easy and to present to the office to see Dr. Carpenter on August 16, 2010.

51. On August 16, 2010, Patricia Merchand presented to see Dr. Carpenter at Mid-Michigan Ear, Nose and Throat, P.C. He placed a drain in the incision. After removing fluid, he re-bandaged the wound.



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52. On August 18, 2010, Patricia Merchand returned to see Dr. Carpenter. The incision was still open. Dr. Carpenter again drained out fluid from the surgical wound. Dr. Carpenter attempted to cauterize the wound with silver nitrate. He prescribed a 10-day supply of Keflex. He recommended Neosporin for the wound. Patricia Merchand advised him that her neck and tongue were numb and she was biting the back of her tongue. He advised her that it was part of the healing process and it would take one to two years to heal.

53. The infection and/or open gapping surgical wound continued to worsen. A red ring developed around the surgical incision. Patricia Merchand continued to experience drainage from the surgical incision.

54. Patricia Merchand returned to see Dr. Carpenter on August 23, 2010. He noted that there was no infection but that there was a seroma which continued to drain. Patricia Merchand requested a different antibiotic. He prescribed Septra/sulfamethoxazole DS 1 BID and cortisporin for the wound.

55. Patricia Merchand returned to see Dr. Carpenter on August 30, 2010. He advised her to continue to use peroxide on the wound daily.

56. Patricia Merchand returned to see Richard Carpenter, M.D., on September 13, 2010. The infection and/or open gapping wound was starting to slowly improve with the sulfamethoxazole. She advised him that she was still biting her tongue and he told her that was part of the healing process and would take one to two years to heal.

57. On March 7, 2011, Patricia Merchand returned to see Dr. Carpenter. She advised him that she still did not feel right and she still was biting the back of her tongue. She continued to have numbness of her tongue. Richard Carpenter, M.D., again advised her it was part of the healing process.



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58. Patricia Merchand began developing difficulty talking and spit was collecting at the right side of her mouth. She noticed that her tongue was developing wrinkling and pulsations. She began experiencing difficulty moving her tongue, paralysis of the tongue, disfigurement of the tongue and pain.

59. She returned to see her primary care physician, Kay McLaughlin, D.O., on May 10, 2012, for the abnormalities of her tongue. She ordered MRIs. The neck MRI revealed denervation (nerve damage) of the right side of the tongue.

60. On June 5, 2012, Patricia Merchand was evaluated by an otolaryngologist, Shannon Radgens, D.O. Examination revealed multiple abnormalities of the tongue including paralysis, poor tongue protrusion, weakness and fasciculations of the tongue. She was advised that the nerves in her face including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, sensory nerves and the hypoglossal nerve, had been damaged during the surgery performed by Dr. Carpenter on August 3, 2010. Dr. Radgens advised her that it was unlikely that she would be a candidate for surgery to repair the damage to the injury to her nerves for her face and tongue due to the passage of time from the original injury.

61. Subsequently, Plaintiff was evaluated by the University of Michigan and advised that there was no surgery or treatment for the nerves to the face, mouth and tongue that Dr. Carpenter injured on August 3, 2010.

62. Plaintiff has developed difficulty in swallowing, speech impairment and aspiration as a result of the damage to the nerves to her mouth and tongue.

63. Plaintiff is being fitted for bite splints to assist in maintaining a patent airway.

64. Plaintiff is undergoing speech therapy for the damaged nerves to her tongue and mouth.



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65. As a proximate result of the Defendants' negligence in performing surgery and negligently injuring Plaintiff's neurologic anatomy including the nerves to the mouth and tongue including, but not limited to, the hypoglossal nerve, Plaintiff has experienced physical pain and suffering, mental, emotional and psychological injury, suffering, trauma, anguish, distress, fright, shock, embarrassment, humiliation, mortification, disfigurement and disability.

66. As a proximate result of the Defendants' negligence in performing surgery and negligently injuring Plaintiff's neurologic anatomy including the nerves to the mouth and tongue including, but not limited to, the hypoglossal nerve, Plaintiff has required additional medical care and will continue to require additional medical care and treatment for her injuries and the residual problems caused by the injury to the nerves to her mouth and tongue.

67. As a proximate result of the Defendants' negligence in performing surgery and negligently injuring Plaintiff's neurologic anatomy including the nerves to the mouth and tongue including, but not limited to, the hypoglossal nerve, Plaintiff has incurred economic expenses, including, but not limited to, medical care and treatment.

68. As a proximate result of the Defendants' negligence in performing surgery and negligently injuring Plaintiff's neurologic anatomy including the nerves to the mouth and tongue including, but not limited to, the hypoglossal nerve, Plaintiff has and will continue to experience economic loss including, but not limited to, for wage loss and wage earning capacity.

69. The standard of care for Defendant Carpenter is that of a reasonable specialist in otolaryngology of ordinary learning, judgment and skill in the same or similar circumstances. The standard of care is a national standard of care for all physicians practicing in the specialty of otolaryngology and is the same, regardless of whether they are board-certified in otolaryngology. The standard of care for Defendant Carpenter as a specialist in otolaryngology and/or a board-

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certified otolaryngology physician, required him to do the following, and to achieve compliance with the standard of care, he was required to do the following with respect to Patricia Merchand:

a. To properly preform the surgery on August 3, 2010, and to make proper incisions in a fashion that would not result in injury to the neurologic anatomy, the nerves for the mouth and tongue, the motor and sensory nerves, the para and sympathetic nerves, the hypoglossal nerve and the lingual nerve.

b. In performing surgical removal of the right submandibular gland on August 3, 2010, to properly identify the anatomy and the landmarks, to properly observe, identify and protect the neurologic anatomy, the anatomy and nerves for the submandibular space, the motor and sensory nerves of the mouth and tongue, the hypoglossal nerve, the lingual nerve and the para and sympathetic nerves.

c. To take appropriate steps during surgery to protect and identify the neurologic anatomy, the nerves to the submandibular space, the mouth and tongue, the hypoglossal nerve, the lingual nerve, the motor and sensory nerves and the para and sympathetic nerves.

d. To take proper precautions during the surgery on August 3, 2010, to identify, protect and not to injure the neurologic anatomy, the anatomy and nerves of the submandibular space, the motor and sensory nerves for the mouth and tongue, the hypoglossal nerve, the lingual nerve and the para and sympathetic nerves.

e. To utilize proper dissection and blunt dissection during surgery.

f. To maintain an appropriate distance during the surgery from the nerves that supply the mouth and tongue, the motor and sensory nerves, the nerves in the

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submandibular space including, but not limited to, the hypoglossal nerve and the lingual nerve.

g. To properly monitor the nerves for the mouth and tongue during surgery including, but not limited to, the nerves in the submandibular space, the lingual nerve, sensory and motor nerves and the hypoglossal nerve.

h. To properly inspect during surgery the operative field and the nerves which supply the mouth and tongue, the nerves in the submandibular space, the motor and sensory nerves, the hypoglossal nerve and the lingual nerve to determine whether they were injured or whether they were properly functioning.

i. To properly perform surgery, properly position the anatomy and structures, to properly dissect and elevate structures and the anatomy to identify and protect the neurologic anatomy, nerves in the submandibular space, the nerves to the mouth and face and to properly utilize surgical instruments in a manner that would not injure or cut the nerves to the mouth and tongue including, but not limited to, the hypoglossal nerve.

j. To specifically identify the hypoglossal nerve during surgery, to protect it during surgery and not to cut it or otherwise injure it.

k. To properly perform the surgery on August 3, 2010, in a manner not to injure the nerves for the mouth and tongue including, but not limited to, the nerves in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves, the lingual nerve and the hypoglossal nerve.

l. Not to injure, bruise, stretch, kink, compress, tear, transect, burn, crush or cut during surgery the nerves to the mouth and tongue including, but not limited to, the

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nerves in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves and the hypoglossal nerve.

m. To identify during the surgery on August 3, 2010, that he injured, stretched, kinked, bruised, cut, tore, crushed, compressed, transected, burned or otherwise impaired the nerves for the mouth and tongue, the nerves in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves and the hypoglossal nerve.

n. To properly diagnose the injury, bruising, stretching, kinking, compressing, tearing, transecting, burning, crushing and/or impairment to the nerves to the mouth and tongue including, but not limited to, the hypoglossal nerve and/or the lingual nerve during surgery and to repair the injured nerves and correct and repair the damage or to properly and/or timely refer Patricia Merchand for diagnosis and repair of the injury to the nerves to her mouth and tongue, including her motor and sensory nerves and hypoglossal nerve.

70. Dr. Carpenter breached the standard of care for physicians specializing in otolaryngology and physicians board-certified in otolaryngology and was negligent in 2010 with respect to Patricia Merchand in the following:

a. Failing to properly perform the surgery on August 3, 2010, and to make proper incisions in a fashion that would not result in injury to the neurologic anatomy, the nerves for the mouth and tongue, the motor and sensory nerves, the para and sympathetic nerves, the hypoglossal nerve and the lingual nerve.

b. In performing surgical removal of the right submandibular gland on August 3, 2010, failing to properly identify the anatomy and the landmarks, to properly observe, identify and protect the neurologic anatomy, the anatomy and nerves for the

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submandibular space, the motor and sensory nerves of the mouth and tongue, the hypoglossal nerve, the lingual nerve and the para and sympathetic nerves.

c. Failing to take appropriate steps during surgery to protect and identify the neurologic anatomy, the nerves to the submandibular space, the mouth and tongue, the hypoglossal nerve, the lingual nerve, the motor and sensory nerves and the para and sympathetic nerves.

d. Failing to take proper precautions during the surgery on August 3, 2010, to identify, protect and not to injure the neurologic anatomy, the anatomy and nerves of the submandibular space, the motor and sensory nerves for the mouth and tongue, the hypoglossal nerve, the lingual nerve and the para and sympathetic nerves.

e. Failing to utilize proper dissection and blunt dissection during surgery.

f. Failing to maintain an appropriate distance during the surgery from the nerves that supply the mouth and tongue, the motor and sensory nerves, the nerves in the submandibular space including, but not limited to, the hypoglossal nerve and the lingual nerve.

g. Failing to properly monitor the nerves for the mouth and tongue during surgery including, but not limited to, the nerves in the submandibular space, the lingual nerve, sensory and motor nerves and the hypoglossal nerve.

h. Failing to properly inspect during surgery the operative field and the nerves which supply the mouth and tongue, the nerves in the submandibular space, the motor and sensory nerves, the hypoglossal nerve and the lingual nerve to determine whether there was injury to the nerves and impaired function.

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i. Failing to properly perform surgery, properly position the anatomy and structures, to properly dissect and elevate structures and the anatomy to identify and protect the neurologic anatomy, nerves in the submandibular space, the nerves to the mouth and face and to properly utilize surgical instruments in a manner that would not injure or cut the nerves to the mouth and tongue including, but not limited to, the hypoglossal nerve.

j. Failing to specifically identify the hypoglossal nerve during surgery; failing to protect it during surgery and cutting or otherwise injure it.

k. Failing to properly perform the surgery on August 3, 2010, in a manner not to injure the nerves for the mouth and tongue including, but not limited to, the nerves in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves, the lingual nerve and the hypoglossal nerve.

l. Negligently injuring, bruising, stretching, kinking, compressing, tearing, transecting, burning, crushing or cutting during surgery the nerves to the mouth and tongue including, but not limited to, the nerves in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves and the hypoglossal nerve.

m. Failing to identify during the surgery on August 3, 2010, that he injured, stretched, kinked, bruised, cut, tore, crushed, compressed, transected, burned or otherwise, impaired the nerves for the mouth and tongue, the nerves in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves and the hypoglossal nerve.

n. Failing to properly diagnose the injury, bruising, stretching, kinking, compressing, tearing, transecting, burning, crushing and/or impairment to the nerves to the



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the mouth and tongue including, but not limited to, the hypoglossal nerve and/or the lingual nerve during surgery and failing to repair the injured nerves and correct and repair the damage or failing to properly and/or timely refer Patricia Merchand for diagnosis and repair of the injury to the nerves to her mouth and tongue, including her motor and sensory nerves and hypoglossal nerve.

71. The manner in which it is claimed that the negligence and breach of the standard of practice and care of Dr. Carpenter was the proximate cause of injury to Patricia Merchand is:

a. If he had properly performed the surgery on August 3, 2010, and made proper incisions in a fashion that would not injury the nerves to the mouth and tongue, the motor and sensory nerves, the para and the sympathetic nerves, the nerves in the submandibular space, the hypoglossal nerve and the lingual nerve, the nerves to the mouth and face including, but not limited to, the hypoglossal nerve would not have been injured.

b. If he had properly identified during surgery the anatomy and the landmarks, and properly observed and identified and protected the neurologic anatomy, the anatomy and nerves for the submandibular space, the motor and sensory nerves of the mouth and tongue, the hypoglossal nerve, the lingual nerve and the para and sympathetic nerves, the nerves to the mouth and tongue including the hypoglossal nerve would not have been injured.

c. If he had taken proper precautions during surgery to identify, protect and not to injure the neurological anatomy, the nerves and structures in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves, the hypoglossal

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d. If he had properly performed the surgery and performed proper dissection and blunt dissection during surgery, he would have visualized, identified and protected the neurologic anatomy, the nerves in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves, the nerves which supply the mouth and tongue, the hypoglossal nerve and the lingual nerve, he would not have cut or injured the nerves for the mouth and tongue including, but not limited to, the motor nerves and the hypoglossal nerve.

e. If he had maintained an appropriate distance during surgery from the neurologic anatomy, the nerves that supply the mouth and tongue, the nerves in the submandibular space, the motor and sensory nerves, the hypoglossal nerve and the lingual nerve, he would not have cut and/or injured the nerves to the mouth and tongue including, but not limited to, the motor nerves and the hypoglossal nerve.

f. If he had properly monitored during surgery the neurologic anatomy, the nerves for the mouth and tongue including, but not limited to, the nerves in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves, the hypoglossal nerve and the lingual nerve, he would not have cut or injured the nerves to the mouth and tongue including, but not limited to, the hypoglossal nerve.

g. If he had properly inspected the operative field, the neurologic anatomy, the submandibular space and the nerves which supply the mouth and tongue, the motor and sensory nerves, the hypoglossal nerve and the lingual nerve, he would have visualized, identified the nerves and he would not have cut and/or injured the nerves to the mouth and tongue including, but not limited to, the hypoglossal nerve during surgery.



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h. If he had properly performed surgery, properly positioned the anatomy and structures, properly dissected and elevated the structures and the anatomy to identify and protect the neurologic anatomy and nerves in the submandibular space and the nerves to the mouth and tongue and properly utilized surgical instruments, he would not have cut and/or injured the nerves to the mouth and tongue including, but not limited to, the hypoglossal nerve.

i. If he had identified the nerves to the mouth and tongue, including the hypoglossal nerve during surgery and maintained a proper distance from it, he would not have cut and/or injured the motor nerves including, but not limited to, the hypoglossal nerve.

j. If he had properly identified the nerves to the mouth and tongue during surgery including, but not limited to, the motor nerves and the hypoglossal nerve, he would not have injured, bruised, stretched, kinked, compressed, torn, transected, burned, crushed, cut or otherwise injured the nerves to the mouth and tongue including, but not limited to, the nerves in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves, the hypoglossal nerve and the lingual nerve.

k. If he had properly inspected the operative field, the submandibular space, the motor and sensory nerves, the para and sympathetic nerves, the motor and sensory nerves to the mouth and tongue, he would have identified that he injured, stretched, kinked, bruised, compressed, tore, cut, transected, burned, crushed, cut or otherwise injured the nerves to the mouth and tongue, the motor nerves, the para and sympathetic nerves and the hypoglossal nerve.



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l. If he had identified that he injured or cut the nerves to the mouth and tongue during surgery including, but not limited to, the motor nerves and the hypoglossal nerve, he would have repaired the damaged nerve and/or made proper arrangements for a referral and/or repair of the damaged motor nerves to the mouth and face. If he had repaired the damaged nerve or referred Patricia Merchand for treatment and repair of the damaged nerves to the mouth and tongue and the hypoglossal nerve, the nerve injury would have been repaired and she would not be experiencing damage to her tongue, denervation of her tongue, multiple abnormalities of her tongue, including paralysis, impaired tongue protrusion, weakness, fasciculations of her tongue, disfigurement of her tongue, impairment of her speech, impaired ability to eat, difficulty swallowing, pain and other damage and impairment to her tongue based on the injury to the nerves of the mouth and face.

m. If during surgery, the nerves for the mouth and tongue had not been injured, Patricia Merchand would not have sustained damages to her tongue, denervation of her tongue, multiple abnormalities of her tongue, including paralysis, impaired tongue protrusion, weakness, fasciculations of her tongue, disfigurement of her tongue, impairment of her ability to talk and eat, difficulty swallowing and pain involving the tongue and other damage to the nerves to her mouth and tongue and other residuals from the nerve damage.

WHEREFORE, Plaintiff Patricia Merchand demands judgment against these Defendants in an amount in excess of Twenty-Five Thousand Dollars ($25,000), as will fully, fairly and adequately compensate Plaintiff, and to which she may be entitled, together with interest, costs and attorney fees.



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**COUNT II**
**DEFENDANT MID-MICHIGAN EAR, NOSE AND THROAT, P.C.**

72. Plaintiff realleges and incorporates by reference paragraphs 1 through 72, as though fully restated herein.

73. At all times pertinent hereto, Richard Carpenter, M.D., was an employee, agent, servant and/or apparent and/or ostensible agent and/or agent by estoppel of Mid-Michigan Ear, Nose and Throat, P.C. Mid-Michigan Ear, Nose and Throat, P.C. is vicariously liable for the negligence of its employees, agents, servants, and/or apparent and/or ostensible agents and/or agents by estoppel, including Richard Carpenter, M.D., pursuant to *respondeat superior*.

74. Mid-Michigan Ear, Nose and Throat, P.C., as a corporation providing healthcare, owed a duty to its patients, including Patricia Merchand, to provide otolaryngology physicians competent to provide proper care and treatment. Richard Carpenter, M.D. was not competent to provide proper care and treatment. Mid-Michigan Ear, Nose and Throat, P.C. is liable for its own negligence in failing to do so, and is vicariously liable for the negligence of Richard Carpenter, M.D.

75. At all times pertinent hereto, Mid-Michigan Ear, Nose and Throat, P.C., owed a duty to their/its patients, including Patricia Merchand, to properly supervise and direct Richard Carpenter, M.D., and is liable for its own negligence in failing to do so and is liable for the negligence of Richard Carpenter, M.D., pursuant to *respondeat superior*, agency and vicarious liability.

WHEREFORE, Plaintiff Patricia Merchand demands judgment against these Defendants in an amount in excess of Twenty-Five Thousand Dollars ($25,000), as will fully, fairly and

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adequately compensate Plaintiff, and to which she may be entitled, together with interest, costs and attorney fees.

Respectfully submitted,

FARHAT & STORY, P.C.
Attorneys for Plaintiff

Dated: December 17, 2012

By: 

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# AFFIDAVIT OF MERITORIOUS CLAIM

STATE OF MARYLAND )
) ss
COUNTY OF MONTGOMERY )

Michael S. Morris, M.D., F.A.C.S., being first duly sworn, says as follows:

1. I am an adult competent to testify in this matter.

2. I am a physician who practices otolaryngology, and I have been board-certified by the American Board of Otolaryngology since 1987. I am a Fellow of the American College of Surgeons.

3. From 1987 through the present the majority of my professional time has been spent in the active clinical practice of otolaryngology.

4. I am familiar with and know the applicable standard of care for physicians practicing otolaryngology and physicians board-certified in otolaryngology for the years 1987 to the present.

5. I have reviewed the Notice of Intent to File Claim and Lawsuit on behalf of Patricia Merchand and all medical records provided to me by Farhat & Story, P.C., including: Mid-Michigan Ear, Nose & Throat, P.C.; Kay McLaughlin, D.O.; Sparrow Health System; Endodontic Specialists, P.C.; Red Cedar ENT & Audiology; Report by John Stanley, M.D., University of Michigan Health System. I have also reviewed a CD of the 5/24/12 MRI Brain and Neck and 6/30/10 CT Neck. I have reviewed pictures of Patricia Merchand's neck and tongue.

6. The factual basis for the claim on behalf of Patricia Merchand is that on August 3, 2010, Dr. Carpenter performed surgery on her. His operative report states that he performed an excision of the submandibular gland, right and stone. In his operative report, he noted identifying the right mandibular branch of the nerve of the face. According to his operative note, he did not locate, identify or protect the neurologic anatomy and the other nerves for the mouth and tongue and the submandibular space including, but not limited to, the motor and sensory nerves, the para and sympathetic nerves, the lingual nerve and the hypoglossal nerve. Dr. Carpenter negligently and improperly performed surgery on Patricia Merchand by failing to identify and protect her neurologic anatomy and the nerves to the mouth and tongue including, but not limited to, the hypoglossal nerve. During surgery, Defendant Carpenter negligently injured the neurologic anatomy and the nerves to her mouth and tongue, including, but not limited to, the hypoglossal nerve. Subsequently, Patricia Merchand developed difficulty talking and other problems associated with her mouth and tongue. Because Dr. Carpenter injured the nerves to her mouth and tongue including the hypoglossal nerve,

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Ms. Merchand's tongue developed wrinkling, pulsation and she began experiencing difficulty moving her tongue, paralysis of her tongue, fasciculations and disfigurement of the tongue and associated pain. She was evaluated by an otolaryngologist, Shannon Radgens, D.O., and was diagnosed with injury to the nerves to her mouth and tongue including, but not limited to, the hypoglossal nerve.

7. At all times pertinent hereto, Richard Carpenter, M.D., upon information and belief, was board certified in otolaryngology and, as such, provided care and treatment to Patricia Merchand in his capacity as a specialist in otolaryngology. The standard of care for Dr. Carpenter, specialists in otolaryngology, including that for a board-certified otolaryngology physicians, is a national standard of care. Since Dr. Carpenter was specializing in otolaryngology in 2010, and since he was board certified in otolaryngology, he owed a duty to Patricia Merchand to provide care and treatment that a reasonably prudent specialist in otolaryngology and a reasonably prudent board-certified otolaryngology physician of ordinary learning, judgment or skill under the same or similar circumstances would and, to achieve compliance with the standard of care, he was required to do the following:

a. To properly preform the surgery on August 3, 2010 and to make proper incisions in a fashion that would not result in injury to the neurologic anatomy, the nerves for the mouth and tongue, the motor and sensory nerves, the para and sympathetic nerves, the hypoglossal nerve and the lingual nerve.

b. In performing surgical removal of the right submandibular gland on August 3, 2010, to properly identify the anatomy and the landmarks, to properly observe, identify and protect the neurologic anatomy, the anatomy and nerves for the submandibular space, the motor and sensory nerves of the mouth and tongue, the hypoglossal nerve, the lingual nerve and the para and sympathetic nerves.

c. To take appropriate steps during surgery to protect and identify the neurologic anatomy, the nerves to the submandibular space, the mouth and tongue, the hypoglossal nerve, the lingual nerve, the motor and sensory nerves and the para and sympathetic nerves.

d. To take proper precautions during the surgery on August 3, 2010, to identify, protect and not to injure the neurologic anatomy, the anatomy and nerves of the submandibular space, the motor and sensory nerves for the mouth and tongue, the hypoglossal nerve, the lingual nerve and the para and sympathetic nerves.

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e. To utilize proper dissection and blunt dissection during surgery.

f. To maintain an appropriate distance during the surgery from the nerves that supply the mouth and tongue, the motor and sensory nerves, the nerves in the submandibular space including, but not limited to, the hypoglossal nerve and the lingual nerve.

g. To properly monitor the nerves for the mouth and tongue during surgery including, but not limited to, the nerves in the submandibular space, the lingual nerve, sensory and motor nerves and the hypoglossal nerve.

h. To properly inspect during surgery the operative field and the nerves which supply the mouth and tongue, the nerves in the submandibular space, the motor and sensory nerves, the hypoglossal nerve and the lingual nerve to determine whether they were injured or whether they were properly functioning.

i. To properly perform surgery, properly position the anatomy and structures, to properly dissect and elevate structures and the anatomy to identify and protect the neurologic anatomy, nerves in the submandibular space, the nerves to the mouth and face and to properly utilize surgical instruments in a manner that would not injure or cut the nerves to the mouth and tongue including, but not limited to, the hypoglossal nerve.

j. To specifically identify the hypoglossal nerve during surgery, to protect it during surgery and not to cut it or otherwise injure it.

k. To properly perform the surgery on August 3, 2010, in a manner not to injure the nerves for the mouth and tongue including, but not limited to, the nerves in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves, the lingual nerve and the hypoglossal nerve.

l. Not to injure, bruise, stretch, kink, compress, tear, transect, burn, crush or cut during surgery the nerves to the mouth and tongue including, but not limited to, the nerves in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves and the hypoglossal nerve.

m. To identify during the surgery on August 3, 2010, that he injured, stretch, kinked, bruised, cut, tore, crushed, compressed, transected, burned or otherwise impaired the nerves for the mouth and tongue, the nerves in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves and the hypoglossal nerve.

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n. To properly diagnose the injury, bruising, stretching, kinking, compressing, tearing, transecting, burning, crushing and/or impairment to the nerves to the mouth and tongue including, but not limited to, the hypoglossal nerve and/or the lingual nerve during surgery and to repair the injured nerves and correct and repair the damage or to properly and/or timely refer Patricia Merchand for diagnosis and repair of the injury to the nerves to her mouth and tongue, including her motor and sensory nerves and hypoglossal nerve.

8. Dr. Carpenter breached the standard of care for physicians specializing in otolaryngology and physicians board-certified in otolaryngology and was negligent in 2010 with respect to Patricia Merchand in the following:

a. Failing to properly perform the surgery on August 3, 2010 and to make proper incisions in a fashion that would not result in injury to the neurologic anatomy, the nerves for the mouth and tongue, the motor and sensory nerves, the para and sympathetic nerves, the hypoglossal nerve and the lingual nerve.

b. In performing surgical removal of the right submandibular gland on August 3, 2010, failing to properly identify the anatomy and the landmarks, to properly observe, identify and protect the neurologic anatomy, the anatomy and nerves for the submandibular space, the motor and sensory nerves of the mouth and tongue, the hypoglossal nerve, the lingual nerve and the para and sympathetic nerves.

c. Failing to take appropriate steps during surgery to protect and identify the neurologic anatomy, the nerves to the submandibular space, the mouth and tongue, the hypoglossal nerve, the lingual nerve, the motor and sensory nerves and the para and sympathetic nerves.

d. Failing to take proper precautions during the surgery on August 3, 2010, to identify, protect and not to injure the neurologic anatomy, the anatomy and nerves of the submandibular space, the motor and sensory nerves for the mouth and tongue, the hypoglossal nerve, the lingual nerve and the para and sympathetic nerves.

e. Failing to utilize proper dissection and blunt dissection during surgery.

f. Failing to maintain an appropriate distance during the surgery from the nerves that supply the mouth and tongue, the motor and sensory nerves, the nerves in the submandibular space including, but not limited to, the hypoglossal nerve and the lingual nerve.

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g. Failing to properly monitor the nerves for the mouth and tongue during surgery including, but not limited to, the nerves in the submandibular space, the lingual nerve, sensory and motor nerves and the hypoglossal nerve.

h. Failing to properly inspect during surgery the operative field and the nerves which supply the mouth and tongue, the nerves in the submandibular space, the motor and sensory nerves, the hypoglossal nerve and the lingual nerve to determine whether there was injury to the nerves and impaired function.

i. Failing to properly perform surgery, properly position the anatomy and structures, to properly dissect and elevate structures and the anatomy to identify and protect the neurologic anatomy, nerves in the submandibular space, the nerves to the mouth and face and to properly utilize surgical instruments in a manner that would not injure or cut the nerves to the mouth and tongue including, but not limited to, the hypoglossal nerve.

j. Failing to specifically identify the hypoglossal nerve during surgery; failing to protect it during surgery and cutting or otherwise injure it.

k. Failing to properly perform the surgery on August 3, 2010, in a manner not to injure the nerves for the mouth and tongue including, but not limited to, the nerves in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves, the lingual nerve and the hypoglossal nerve.

l. Negligently injuring, bruising, stretching, kinking, compressing, tearing, transecting, burning, crushing or cutting during surgery the nerves to the mouth and tongue including, but not limited to, the nerves in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves and the hypoglossal nerve.

m. Failing to identify during the surgery on August 3, 2010, that he injured, stretched, kinked, bruised, cut, tore crushed, compressed, transected, burned or otherwise, impaired the nerves for the mouth and tongue, the nerves in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves and the hypoglossal nerve.

n. Failing to properly diagnose the injury, bruising, stretching, kinking, compressing, tearing, transecting, burning, crushing and/or impairment to the nerves to the mouth and tongue including, but not limited to, the hypoglossal nerve and/or the lingual nerve during surgery and failing to

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repair the injured nerves and correct and repair the damage or failing to properly and/or timely refer Patricia Merchand for diagnosis and repair of the injury to the nerves to her mouth and tongue, including her motor and sensory nerves and hypoglossal nerve.

9. The manner in which it is claimed that the negligence and breach of the standard of practice and care of Dr. Carpenter was the proximate cause of injury to Patricia Merchand was:

a. If he had properly preformed the surgery on August 3, 2010 and made proper incisions in a fashion that would not injury the nerves to the mouth and tongue, the motor and sensory nerves, the para and the sympathetic nerves, the nerves in the submandibular space, the hypoglossal nerve and the lingual nerve, the nerves to the mouth and face including, but not limited to, the hypoglossal nerve would not have been injured.

b. If he had properly identified during surgery the anatomy and the landmarks, and properly observed and identified and protected the neurologic anatomy, the anatomy and nerves for the submandibular space, the motor and sensory nerves of the mouth and tongue, the hypoglossal nerve, the lingual nerve and the para and sympathetic nerves, the nerves to the mouth and tongue including the hypoglossal nerve would not have been injured.

c. If he had taken proper precautions during surgery to identify, protect and not to injure the neurological anatomy, the nerves and structures in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves, the hypoglossal nerve and the lingual nerve, he would not have injured nerves to the mouth and tongue including, but not limited to, the motor and sensory nerves and the hypoglossal nerve.

d. If he had properly performed the surgery and performed proper dissection and blunt dissection during surgery, he would have visualized, identified and protected the neurologic anatomy, the nerves in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves, the nerves which supply the mouth and tongue, the hypoglossal nerve and the lingual nerve, he would not have cut or injured the nerves for the mouth and tongue including, but not limited to, the motor nerves and the hypoglossal nerve.

e. If he had maintained an appropriate distance during surgery from the neurologic anatomy, the nerves that supply the mouth and tongue, the nerves in the submandibular space, the motor and sensory nerves, the

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hypoglossal nerve and the lingual nerve, he would not have cut and/or injured the nerves to the mouth and tongue including, but not limited to, the motor nerves and the hypoglossal nerve.

f. If he had properly monitored during surgery the neurologic anatomy, the nerves for the mouth and tongue including, but not limited to, the nerves in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves, the hypoglossal nerve and the lingual nerve, he would not have cut or injured the nerves to the mouth and tongue including, but not limited to, the hypoglossal nerve.

g. If he had properly inspected the operative field, the neurologic anatomy, the submandibular space and the nerves which supply the mouth and tongue, the motor and sensory nerves, the hypoglossal nerve and the lingual nerve, he would have visualized, identified the nerves and he would not have cut and/or injured the nerves to the mouth and tongue including, but not limited to, the hypoglossal nerve during surgery.

h. If he had properly performed surgery, properly positioned the anatomy and structures, properly dissected and elevated the structures and the anatomy to identify and protect the neurologic anatomy and nerves in the submandibular space and the nerves to the mouth and tongue and properly utilized surgical instruments, he would not have cut and/or injured the nerves to the mouth and tongue including, but not limited to, the hypoglossal nerve.

i. If he had identified the nerves to the mouth and tongue, including the hypoglossal nerve during surgery and maintained a proper distance from it, he would not have cut and/or injured the motor nerves including, but not limited to, the hypoglossal nerve.

j. If he had properly identified the nerves to the mouth and tongue during surgery including, but not limited to, the motor nerves and the hypoglossal nerve, he would not have injured, bruised, stretched, kinked, compressed, torn, transected, burned, crushed, cut or otherwise injured the nerves to the mouth and tongue including, but not limited to, the nerves in the submandibular space, the motor and sensory nerves, the para and sympathetic nerves, the hypoglossal nerve and the lingual nerve.

k. If he had properly inspected the operative field, the submandibular space, the motor and sensory nerves, the para and sympathetic nerves, the motor and sensory nerves to the mouth and tongue, he would have identified that he injured, stretched, kinked, bruised, compressed, tore, cut, transected,

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burned, crushed, cut or otherwise injured the nerves to the mouth and tongue, the motor nerves, the para and sympathetic nerves and the hypoglossal nerve.

l. If he had identified that he injured or cut the nerves to the mouth and tongue during surgery including, but not limited to, the motor nerves and the hypoglossal nerve, he would have repaired the damaged nerve and or made proper arrangements for a referral and/or repair of the damaged motor nerves to the mouth and face. If he had repaired the damaged nerve or referred Patricia Merchand for treatment and repair of the damaged nerves to the mouth and tongue and the hypoglossal nerve, the nerve injury would have been repaired and she would not be experiencing damage to her tongue, denervation of her tongue, multiple abnormalities of her tongue, including paralysis, impaired tongue protrusion, weakness, fasciculations of her tongue, disfigurement of her tongue, impairment of her speech, impaired ability to eat, difficulty swallowing, pain and other damage and impairment to her tongue based on the injury to the nerves of the mouth and face.

m. If during surgery, the nerves for the mouth and tongue had not been injured, Patricia Merchand would not have sustained damages to her tongue, denervation of her tongue, multiple abnormalities of her tongue, including paralysis, impaired tongue protrusion, weakness, fasciculations of her tongue, disfigurement of her tongue, impairment of her ability to talk and eat, difficulty swallowing and pain involving the tongue and other damage to the nerves to her mouth and tongue and other residuals from the nerve damage.

10. My opinions are based on the medical records and radiology studies that I have reviewed. Any additional information, including deposition testimony and medical records, may or may not change my opinion.

11. My opinions are to a reasonable degree of medical certainty.

12. The claim on behalf of Patricia Merchand is meritorious.

13. I have read the contents of this affidavit and my statements are made voluntarily, based on personal knowledge of the statements contained herein and, if called as a witness, I can testify competently as to the facts contained in the affidavit.

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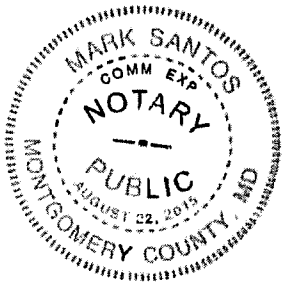
Further Affiant sayeth not.

Michael S. Morris, M.D., F.A.C.S.

Sworn to and subscribed before me on the 18th day of October, 2012, I certify that the person signing this affidavit did so personally and voluntarily in my presence on the date indicated, that I verified the Affiant's identity, and that I administered an oath or affirmation to the Affiant, who swore to, or affirmed to me, to the best of his knowledge, information and belief, the truth and accuracy of the contents of the Affidavit.

Notary Public
Mark Santos
Print name of Notary
Montgomery County, Maryland
My Commission Expires: 8/22/12

AFFIX SEAL

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**STATE OF MICHIGAN**
**INGHAM COUNTY CIRCUIT COURT**

PATRICIA MERCHAND,

Plaintiff,

v

RICHARD CARPENTER, M.D., and MID-MICHIGAN EAR, NOSE AND THROAT, P.C., a domestic professional service corporation, jointly and severally,

Defendants.

File No. 12-_____-NH

Hon. _____

Kitty L. Groh (P36722)
Farhat & Story, P.C.
Attorneys for Plaintiff
1003 North Washington Avenue
Lansing, MI 48906-4868
(517) 351-3700

**AFFIDAVIT OF KITTY L. GROH**

STATE OF MICHIGAN )
) ss
COUNTY OF INGHAM )

Kitty L. Groh, being duly sworn, says as follows:

1. I am an adult competent to testify in this matter.

2. I am the attorney for Plaintiff in the above-captioned matter.

3. Plaintiff has filed her Complaint and Affidavit of Meritorious Claim of Michael S. Morris, M.D., F.A.C.S., whom Plaintiff's attorney reasonably believes is qualified and meets the requirements for expert witnesses, pursuant to MCL 600.2912d and MCL 600.2169.

4. Dr. Morris stated in his affidavit that he was board-certified by the American Board of Otolaryngology in 1987 to the present and spent the majority of his professional time in the active clinical practice of otolaryngology.

5. The American Board of Medical Specialties indicates that Dr. Carpenter is board-certified in otolaryngology. The website of Mid-Michigan Ear, Nose and Throat, P.C. indicates that Dr. Carpenter is a board-certified otolaryngologist. The Sparrow Hospital website lists Dr. Carpenter as a board-certified otolaryngologist.

6. I am an adult competent to testify and I can testify competently to the facts contained in this Affidavit. I have read the contents of this Affidavit and my statements are made voluntarily and I make this Affidavit based on personal knowledge of the statements contained herein.

Further Affiant sayeth not.

Kitty L. Groh

Sworn to and subscribed before me on the 17th day of December, 2012.

DIANNE C ALEXANIAN
Notary Public - Michigan
Ingham County
My Commission Expires Jun 18, 2018
Acting in the County of _____

Dianne C. Alexanian, Notary Public
County of Ingham
My Commission Expires: June 18, 2018

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# EXHIBIT F

91 Fed.Appx. 384
This case was not selected for publication in the Federal Reporter.
Not for Publication in West's Federal Reporter.
See Fed. Rule of Appellate Procedure 32.1 generally governing citation of judicial decisions issued on or after Jan. 1, 2007. See also Sixth Circuit Rule 28. (Find CTA6 Rule 28)
United States Court of Appeals, Sixth Circuit.

Kathleen CETLINSKI, James Cetlinski, Deborah Gothro, and Roger Gothro, Plaintiffs–Appellants,
v.
Jeffrey BROWN, M.D. and Associated Physicians of MCO, Inc., Defendants–Appellees.

No. 02–3199.
|
Jan. 14, 2004.

## Synopsis

**Background:** Patients brought action against physician and his employer under § 1983, and claims of medical negligence, intentional infliction of emotional distress, negligent infliction of emotional distress, fraud, and promissory estoppel alleging physician performed an experimental procedure on them without obtaining informed consent. The United States District Court for the Northern District of Ohio entered judgment after jury verdict in favor of defendants. Plaintiffs appealed.

**Holdings:** The Court of Appeals, Rogers, Circuit Judge, held that:

[1] patients were not prejudiced by alleged non-disclosure of defense experts' prospective testimony on informed consent issue;

[2] probative value of testimony of physician's other patients was substantially outweighed by danger of unfair prejudice; and

[3] plaintiffs were not prejudiced by admission of videotape produced after trial commenced.

Affirmed.

West Headnotes (3)

**[1] Federal Courts**
Preliminary proceedings; depositions and discovery

170B Federal Courts
170BXVII Courts of Appeals
170BXVII(K) Scope and Extent of Review
170BXVII(K)4 Harmless and Reversible Error
170Bk3686 Particular Errors as Harmless or Prejudicial
170Bk3695 Preliminary proceedings; depositions and discovery
(Formerly 170Bk895)

  

Patients were not prejudiced by alleged non-disclosure of defense experts' prospective testimony on informed consent issue in expert reports and thus patients were not entitled to a new trial in medical malpractice action against physician and his employer; patients did not disagree with experts' definition of informed consent, expert reports clearly stated procedure was not experimental, patients conceded that consent forms they signed were appropriate for nonexperimental procedures, issue of informed consent was at heart of case, and patients declined to depose experts before trial. Fed.Rules Civ.Proc.Rule 26(a), 28 U.S.C.A.

Cases that cite this headnote

**[2] Evidence**

Tendency to mislead or confuse

157 Evidence
157IV Admissibility in General
157IV(D) Materiality
157k146 Tendency to mislead or confuse

In medical malpractice action, probative value of testimony of physician's other patients, who underwent same surgery, about their results was substantially outweighed by danger of unfair prejudice; other patients were allowed to testify about pre-operational things, results of other surgeries had little bearing on whether or not surgery was considered experimental at time plaintiffs underwent procedure, and admission of testimony would have created confusion of issues and undue delay. Fed.Rules Evid.Rule 403, 28 U.S.C.A.

1 Cases that cite this headnote

**[3] Federal Courts**

Preliminary proceedings; depositions and discovery

170B Federal Courts
170BXVII Courts of Appeals
170BXVII(K) Scope and Extent of Review
170BXVII(K)4 Harmless and Reversible Error
170Bk3686 Particular Errors as Harmless or Prejudicial
170Bk3695 Preliminary proceedings; depositions and discovery
(Formerly 170Bk895)

In medical malpractice action, plaintiffs were not prejudiced by admission of videotape produced after trial commenced which contained one plaintiff stating that surgery improved her condition and relieved her pain; although plaintiffs' counsel did not receive tape until after trial commenced, tape had been mailed to counsel a week before trial, plaintiff admitted she experienced temporary relief after surgery, tape went towards damages issue which jury did not reach, plaintiffs did not explain why they required additional preparation time, and plaintiffs' counsel also made untimely disclosures.

Cases that cite this headnote

*385 On Appeal from the United States District Court for the Northern District of Ohio.

**Attorneys and Law Firms**

Patrick J. Burkett, Sommers, Schwartz, Silver & Schwartz, Gary A. Krochmal, Freedman, Krochmal, Goldin, Smith & Harris, Southfield, MI, for Plaintiffs–Appellants.

Brian D. Sullivan, Michael F. Schmitz, Reminger & Reminger, Steven J. Hupp, Patrick J. Quallich, Bonezzi, Switzer, Murphy & Polito, Cleveland, OH, for Defendants–Appellees.

Before RYAN, MOORE, and ROGERS, Circuit Judges.

**Opinion**

ROGERS, Circuit Judge.

**1 Kathleen Cetlinski ("Cetlinski") and Deborah Gothro ("Gothro") charge that Dr. Jeffrey Brown performed an experimental procedure–motor cortex stimulation surgery–on them without obtaining informed consent. Cetlinski and Gothro, and their husbands, filed suit against *386 Brown and his employer, the Associated Physicians of Medical College of Ohio, Inc. ("APMCO"). in the United States District Court for the Northern District of Ohio. The plaintiffs asserted a claim under 42 U.S.C. § 1983, and claims of medical negligence, intentional infliction of emotional distress, negligent infliction of emotional distress, fraud, and promissory estoppel against the defendants. A jury found for the defendants on all counts.

The plaintiffs now appeal three evidentiary rulings made by the district court. Specifically, the plaintiffs argue that the district court erred by (1) refusing to exclude "surprise" testimony from defense experts on the issue of informed consent, (2) excluding testimony from other patients of Brown about the results of their surgeries, and (3) refusing to exclude a videotape of Gothro (which was not timely produced by the defendants). The defendants purport to cross-appeal, though they did not file a notice of cross appeal. The defendants argue that the district court erred by permitting testimony from other patients of Brown concerning their "pre-operative care" and by denying their motion for a directed verdict.

The plaintiffs have not shown that they were prejudiced by any of the alleged errors. Therefore, we affirm the judgment of the district court.

## BACKGROUND

*1. The Surgeries.*

In 1998, Brown performed motor cortex stimulation surgery ("MCSS") on Gothro and on Cetlinski. MCSS entails a pair of operations. First, an electrode is surgically implanted onto the patient's dura (the outer covering of the brain). The physician

then administers electrical stimulation and assesses the patient's pain relief. Second, if the patient reports sufficient pain relief, a pulse generator is implanted, and a wire is placed under the skin from the pulse generator to the electrode.

Gothro suffered from severe facial pain after she was struck in the face with a brick while riding in an automobile. Gothro was referred to Brown by her family doctor who was familiar with Brown's work performing balloon implants, a different procedure. On January 22, 1998. Brown examined Gothro and discussed possible treatments, including MCSS. According to Gothro, Brown's assistant stated that the procedure "had been done hundreds of time and that it was very successful in France and Germany," and Brown stated that the procedure "would make [her] hundred percent [sic] pain-free and that [she] would get [her] life back." Also according to Gothro, Brown's assistant showed Gothro a map with red pushpins that purportedly marked the residences of patients who had successfully undergone MCSS; she placed another pushpin at the spot of Gothro's residence and stated "this is going to be you." According to Brown, he and Gothro discussed the complications and risks associated with the procedure.

**2 On January 23, 1998, Brown performed the first operation on Gothro. A few days later, after an apparently successful trial period, he performed the second operation. Prior to each operation, Gothro signed a standard consent form.

Initially, Gothro experienced some relief from her facial pain. However, "eventually, everything started tapering off until [she] was receiving no help from it whatsoever." Additionally, Gothro reports that the procedure has created new problems. She states that she receives a shock from the electrode when she passes underneath high power lines, when she passes through security screening devices, and when she approaches magnets. She also states that *387 the pulse generator and the wire cause extreme pain and discomfort.

Cetlinski suffered from severe facial pain as a result of a dental injection. Cetlinski received Brown's name from an oral surgeon, and, in February 1998, she contacted Brown's office. Brown informed her that he "had this procedure that helped for what [she] was having."

On March 19, 1999, Cetlinski met with Brown. Brown examined Cetlinski and discussed possible treatments, including MCSS. According to Cetlinski, Brown told her that she would be "pain-free" and showed her the map with the red pushpins. According to Brown, he informed Cetlinski that, on average, MCSS patients experience only a 50% pain reduction. Also according to Brown, he cautioned that he could not guarantee that the procedure would be successful. Prior to Cetlinski's surgery, Brown arranged a meeting between Cetlinski and Gothro, who had already undergone the procedure, to discuss the pros and cons of MCSS.

 

On April 17, 1998, Brown performed the first operation on Cetlinski. On April 21, 1998. after an apparently successful test period, he performed the second operation. Cetlinski executed a standard consent form before both operations.[1] According to Cetlinski, Brown gave her a booklet describing the pulse generator, but only after the second operation.

1 Later, in March 1999, Brown sent an additional consent form to Gothro and Cetlinski. According to Gothro and Cetlinski, the new form belatedly disclosed that their surgeries were part of a "research study." According to Brown, the new form did not indicate that Gothro and Cetlinski had been part of a research study; instead, it simply requested Gothro's and Cetlinski's consent for the inclusion of their surgeries in a study.

Cetlinski reports that "her life is worse" after the procedure. Initially, she experienced some relief from her facial pain, but soon it returned to pre-operation level. Moreover, the pulse generator. which turns on by itself and sends "an electrical current through [her] body" that makes her feel like she is being "electrocuted," causes her to suffer additional pain.

*2. Procedural History.*

*a. The Lawsuit.*

On February 1, 2000, Gothro and Cetlinski, and their husbands, initiated this action by filing a complaint against Brown and APMCO in the District Court for the Northern District of Ohio. Stated generally, the plaintiffs' charges were that Brown performed an experimental procedure (*i.e.,* MCSS) on Gothro and Cetlinski without obtaining their informed consent by explaining the experimental nature of the procedure and by disclosing that they were part of a research study. In their amended complaint, the plaintiffs asserted medical negligence, substantive due process (actionable under § 1983), intentional infliction of emotional distress, negligent infliction of emotional distress, fraud, and promissory estoppel claims against the defendants.

*b. Defense Experts.*

**3 About five months before trial, on August 13, 2001, the plaintiffs moved to prohibit the defendants' experts from testifying. The plaintiffs asserted that the experts' reports failed to disclose adequately their opinions and the bases for their opinions in violation of Fed.R.Civ.P. 26(a)(2). The defendants provided supplemental reports and, on December 19, 2001, the district court entered an order denying the plaintiff's motion.

On January 9, 2002, while taking the *de bene esse* deposition of Dr. Robert M. Levy, one of the defense experts, plaintiffs' ***388** attorney learned that Levy intended to opine on the issue of informed consent. On January 14, 2002, the plaintiffs moved to strike Levy's testimony on the issue on the grounds that Levy–in violation of Fed.R.Civ.P. 26(a)(2)–had not disclosed in his expert report that he intended to testify on the informed consent issue. Additionally, during the trial, the plaintiffs objected on the same ground to testimony on the issue by Dr. Kenneth A. Follett, another defense expert.

  

At trial, during Follett's testimony, the district court ruled that Levy and Follett could testify on the informed consent issue.[2] The court noted that the expert reports by Levy and Follett stated that they would testify that Brown had met "the standard of care," and it concluded that "the standard of care" encompassed the obligation to obtain the informed consent of the patient.

2 The district court did not rule on the plaintiff's motion to strike Levy's testimony prior to the trial. Instead, the district court ruled on the plaintiffs' objections to the testimony of both experts when the issue came up during Follett's direct testimony.

At trial, Follett opined that the standard consent form executed by Gothro and Cetlinski prior to their operations "meets the essential elements of informed consent" under the circumstances. During his deposition, which was played at trial, Levy opined that Brown had "proper and adequate informed consent" for the procedures.

*c. Exclusion of Testimony from Other MCSS Patients of Brown.*

On January 7, 2000, the defendants filed a motion in limine to exclude the testimony of Olin Hasty, a former patient of Brown who underwent MCSS. They argued that, since the parties had been unable to obtain Hasty's medical records, they would not have a fair opportunity to cross-examine Hasty or to challenge plaintiffs' counsel's attempt to analogize Hasty's case to Gothro's and Cetlinski's cases. On the same day, the defendants filed a second motion in limine to exclude the testimony of additional, as-yet-unnamed patients of Brown who underwent MCSS. They argued that they would be prejudiced by this testimony in that they would be "forced to try several tangential malpractice cases within the *Cetlinski/Gothro* case" and in that they would not have the records of these patients to use in cross-examination.

The district court granted the defendants' motions in part. It ruled that Brown's other MCSS patients could testify about "pre-operational things" (*e.g.*, whether they received a consent form and whether they signed the form) but not about the results of the surgeries. The court did not explicate its reasoning.

*d. The Gothro Videotape.*

**4 During the trial, defense counsel handed plaintiffs' counsel a videotape depicting Gothro shortly after surgery.[3] The videotape was shot by Brown in his office at some undetermined time after Gothro's surgeries, and it shows Gothro answering a series of questions from Brown about her post-surgical condition. In the videotape, Gothro appears healthy, and she reports that the procedure had succeeded in relieving her pain. In particular, she stated that she experienced an 85% reduction in pain (90% when the pulse generator was on), that she no longer needed pain medication, and that she was considering returning to college. When asked why the ***389** videotape had not been produced earlier, defense counsel explained that Brown had just located the videotape because, until recently, he had not "look[ed] through the right things."[4]

  

3 Defense counsel had mailed the videotape to plaintiffs' counsel the week before trial. However, it did not arrive at his office (located in Michigan) until after he left for trial (in Ohio).

4 Specifically, defense counsel stated, "We couldn't find it. Dr. Brown–No.1, when Dr. Brown left [APMCO], things were left at [APMCO]. He didn't know where things were, et cetera, et cetera, and it was a matter of trying to find it among a lot of different things." He advised that Brown had found the videotape "among some personal possessions that he had at home." He continued, "I think they had been looked through but they just, it wasn't found. It was a matter of looking through the right things and getting it from the right things."

The district court admitted the videotape over the plaintiffs' objection. The court reasoned that, as it was allowing the plaintiffs to present the testimony of witnesses who had not been identified timely, "[s]auce for the goose, sauce for the gander." It further reasoned that it did not "think anybody is being hurt by these problems in late production."

*e. Disposition of the Case.*

On January 25, 2002, a jury returned a verdict in favor of the defendants. On January 29, 2002, the district court entered judgment in favor of the defendants. On February 11, 2002, the plaintiffs filed a timely notice of appeal. The defendants did not file a notice of cross-appeal, though they raised a number of "cross-assignments of error" in their reply briefs.

## ANALYSIS

*1. "Surprise" Testimony of Defense Experts on the Informed Consent Issue.*

**[1]** The alleged failure of the defense experts to disclose their prospective testimony on the "informed consent" issue in their expert reports does not constitute grounds for a new trial, as the plaintiffs have not explained how they were prejudiced by the alleged non-disclosure.

This court reviews a district court's rulings concerning the admission of expert testimony for an abuse of discretion. *Pride v. BIC Corp.*, 218 F.3d 566, 575 (6th Cir.2000); *King v. Ford Motor Co.*, 209 F.3d 886, 900 (6th Cir.2000). "A finding of abuse of discretion will be made only where the reviewing court is firmly convinced that a mistake has been made." *Greenwell v. Boatright*, 184 F.3d 492, 495 (6th Cir.1999) (internal quotation omitted). Moreover, "even if the trial court abuses its discretion, a new trial is not required unless 'substantial rights' of a party are affected." *United States v. Cope*, 312 F.3d 757, 775 (6th Cir.2002) (internal quotation marks and citations omitted). The burden of showing harmful prejudice rests on the party seeking the new trial. *Tobin v. Astra Pharm. Prods., Inc.*, 993 F.2d 528, 541 (6th Cir.1993).

Rule 26(a) of the Federal Rules of Civil Procedure requires an expert witness to provide a written report containing, *inter alia*, (1) "a complete statement of all opinions to be expressed and the basis and reasons therefor," and (2) "the data or other information considered by the witness in forming the opinions." Fed.R.Civ.P. 26(a)(2)(B). Relatedly, Rule 37(c) provides that "a party that without substantial justification fails to disclose information required by

  

Rule 26(a) ... is not. unless such failure is harmless, permitted to use as evidence at trial ... any witness or information not so disclosed." Fed.R.Civ.P. 37(c)(1). Rule 37(c) further provides that "[i]n addition to or in lieu of this sanction, the court ... may impose other appropriate sanctions." *Id.*

**5 The plaintiffs contend that the defense experts violated Rule 26(a) by failing to *390 disclose in their expert reports that they would testify on the "informed consent" issue. In his supplemental report. Dr. Levy stated

> ... I hold the opinion that Dr. Brown's care of these two patients was entirely within the standard of care.

My specific opinions include:

(1) The procedure of motor cortical stimulation for chronic pain is not experimental.

(2) While not an FDA approved procedure, and many common neurosurgical pain procedures are not FDA approved, motor cortex stimulation is appropriately performed using a treating physician's discretion, so called "off label" use. This off label use is supported by the published literature, presentations at national and international meetings and the clinical experience of several neurosurgeons around the world. There is no standard of care requirement that a physician discuss off label use with their patients and it was not necessary that Dr. Brown advise either of these patients of this.

(3) Dr. Brown used good clinical judgment in the evaluation, diagnosis and treatment of these two patients.

(4) Psychiatric or psychological evaluation of patients prior to motor cortex stimulation is not required under the standard of care, nor is it absolutely necessary in and of itself prior to the trial of motor cortical stimulation for chronic pain.

J.A. at 111.

In his initial report, Dr. Follett wrote as follows:

> Based upon my review of the records, I believe Dr. Brown complied with a reasonable standard of care in the treatment of these patients with complex pain disorders. As noted in the records, these individuals received extensive conservative care of their chronic pain disorders prior to undergoing surgical treatment. The surgical treatment (implantation of a motor cortex stimulation system) was carried out using the standard accepted approach, including a "trial" period of stimulation (which

  

> provided good pain relief for both individuals) prior to implantation of the subcutaneous battery pack. This surgery is not experimental. It is a reasonable option for the treatment of intractable neuropathic pain. I find no information in any of the records I have reviewed that Dr. Brown caused either of these individuals injury or harm.

J.A. at 72.

The district court concluded that the experts adequately disclosed their prospective testimony on the "informed consent" issue. The court reasoned that it agreed "with the basic contention that in a case of this sort with the issues that this case clearly presents and has been apparent from day one [sic], the standard of care encompasses notifying the patient of what the patient needs to be notified about and securing consent." J.A. at 534; *see also* J.A. at 536 (stating that the issue of "informed consent" is "the heart of the case" and that the experts' testimony was foreseeable). [5]

5 The plaintiffs framed Brown's alleged failure to obtain informed consent as a violation of the "standard of care." For example, in their amended complaint, the plaintiffs allege that Brown violated "the standard of practice" by failing "to obtain proper Informed Consent," "to inform Plaintiffs that the surgery was experimental," and "to inform Plaintiffs that they would be part of a research study." J.A. at 39. Similarly, in his expert report, one of the plaintiffs' experts opined that Brown "fell below the standard of care" by failing to inform Cetlinski of "the experimental nature of this procedure." J.A. at 74. Likewise, in his expert report, another of the plaintiffs' experts opined that "there was a violation of the standard of care by failing to fully and completely inform Deborah Gothro and Kathleen Cetlinski of the nature of the surgery they were to undergo." J.A. at 80. Finally, plaintiffs' expert opined that Gothro and Cetlinski did not receive "the appropriate informed consent that would meet the applicable, appropriate standard of care." J.A. at 344.

***391** On appeal, the plaintiffs challenge the district court's conclusion that the reports adequately disclosed the expert's prospective testimony on the "informed consent" issue. They argue that generic references to the "standard of care" did not satisfy Rule 26(a)(2)(B)'s mandate, as a number of issues fell under the "standard of care" rubric (specifically, whether the procedure was experimental and whether Brown obtained informed consent). Appellants' Br. at 35, 38. Moreover, they assert that, in any event, the mere assertion that Brown satisfied "the standard of care" hardly qualifies as a complete statement of the experts' opinions on the issue of informed consent. *Id.* at 35, 37. Finally, they claim that they suffered prejudice as plaintiffs' counsel was denied ammunition for cross-examination and was forced to scramble at the last minute to meet the testimony. *Id.* at 36.

****6** Assuming *arguendo* that the expert reports were inadequate, the plaintiffs have not shown prejudice from the admission of the testimony, as required for a new trial. In the testimony cited by the plaintiffs' (Appellants' Br. at 27), the experts opine on three subjects. First, they define the concept of "informed consent." J.A. at 543–44, 590. Second, they opine that MCSS is not an experimental procedure. J.A. at 548–

49. Third, they opine that Brown obtained informed consent by having Gothro and Cetlinski review and execute the standard consent form, given that MCSS is not an experimental procedure. J.A. at 544–47, 590.

Fatally, the plaintiffs have not explained how they were unfairly prejudiced by any of these lines of questioning. First, the plaintiffs have not stated that they disagree with the definition of informed consent offered by the defense experts. Second, the reports clearly disclose the opinion that MCSS was not an "experimental" procedure. J.A. at 72, 111. Third, it appears that the plaintiffs concede that the consent forms executed by Gotho and Cetlinski were appropriate for "non-experimental" procedures. *See* J.A. at 354. In short, the plaintiffs' case of prejudice is premised entirely on bald assertions of "harm" and "prejudice."

Moreover, it is dubious that the plaintiffs were "surprised" by–and unable to prepare for–the testimony that Brown obtained informed consent. As the district court observed, the issue of informed consent is "the heart of the case." and the plaintiffs must have foreseen the experts' testimony. Additionally, the experts were simply borrowing the plaintiffs' phraseology when they framed their testimony in terms of "the standard of care." Finally, the plaintiffs could have avoided any surprise by deposing the experts, which they declined to do. *See Brewer v. Webster County Coal Co.,* No. 96–5960, 1998 WL 199727. at *2 (6th Cir. April 16, 1998) (noting that "any surprise that plaintiff may have experienced cannot be laid at the feet of the trial court, but instead would have been the result of his failure to depose Smith or otherwise prepare for trial").

In conclusion, the district court did not abuse its discretion in admitting the testimony ***392** of the defense experts on the issue of informed consent.

*2. The Exclusion of Testimony from Brown's Other MCSS Patients Concerning the Results of Their Surgeries.*

**[2]** The district court's exclusion of testimony from Brown's other MCSS patients about the results of their surgeries does not constitute grounds for a new trial, as the testimony was properly excluded under Fed.R.Evid. 403 and as the plaintiffs have not shown prejudice from the exclusion of the testimony.

This court reviews a district court's evidentiary rulings for abuse of discretion, and a district court's judgment will be reversed only if the abuse of discretion caused more than harmless error. *Argentine v. United Steelworkers of Am.,* 287 F.3d 476, 486 (6th Cir.2002); *Trepel v. Roadway Exp., Inc.,* 194 F.3d 708, 716 (6th Cir.1999). "Broad discretion is given to district courts in determinations of admissibility based on considerations of relevance and prejudice, and those decisions will not be lightly overruled." *United States v. Jackson–Randolph,* 282 F.3d 369, 376 (6th Cir.2002).

****7** As defined by the Federal Rules of Evidence, relevant evidence is "evidence having any tendency to make the existence of any fact that is of consequence to the

determination of the action more probable or less probable than it would be without the evidence." Fed.R.Evid. 401. All relevant evidence is admissible. Fed.R.Evid. 402. However,

> Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence.

Fed.R.Evid. 403.

On appeal, the plaintiffs assert that their case "was sorely prejudiced" by the district court's ruling that Brown's other MCSS patients could testify about "pre-operational things" (*e.g.*, whether they received a consent form and whether they signed it) but not about the results of their surgeries. J.A. at 264–65. The plaintiffs explain that the former patients would have testified that their results "were no better" than Cetlinksi's and Gothro's results, and the plaintiffs contend that this testimony would have helped show that MCSS was an experimental procedure. Appellants' Br. at 41–42. "Evidence that this surgery never helped anyone," they summarize, "legitimately proves its intrinsically experimental nature." *Id.* at 42.

The district court properly concluded that the testimony should be excluded under Fed.R.Evid. 403.[6] The testimony has minimal relevance, if any, to the issue of the "experimental" nature of MCSS. As framed by the plaintiffs, the issue of whether a procedure is "experimental" turns on whether there was a "long-term ***393** track record over many years" showing positive results. J.A. at 193.[7] Testimony that Brown did not successfully treat his other six MCSS patients–only one or two of whom had the surgery prior to the plaintiffs–adds little to the plaintiffs' argument that MCSS lacked "a track-record" when Gothro and Cetlinski were subjected to the procedure. Given the small number of the other surgeries (six), the timing of the other surgeries (all but one or two were performed after the plaintiffs' surgeries), and the inability to assess the long-term results of the other surgeries at the time of the plaintiffs' surgeries (Brown's earliest surgery was performed approximately four months before Gothro's surgery), the results of the other surgeries–positive or negative–have little bearing on the classification of MCSS at the time the plaintiffs' underwent the procedure.

6 From a review of the transcript, the basis of the district court's ruling is not entirely clear. *See* J.A. at 264–65. However, in their briefs, the parties agree that the district court excluded the testimony under Fed.R.Evid. 403. *See* Appellant's Br. at 40 ("The District Court found merit, in part, in Defendants' argument that such testimony would lead to confusion of the issues, and unduly burden the defense with mini-trials in the nature of additional medical malpractice cases not involving these Plaintiffs."); Brown's Br. at 31 (arguing that the trial court did not abuse its discretion in weighing the probative value of the evidence against Rule 403's exclusionary factors); *see also In re Air Crash Disaster,*

  

86 F.3d 498, 530 n. 21 (6th Cir.1996) (noting that the court could affirm the district court's exclusion of evidence on the authority of Fed.R.Evid. 403 even though the district court based its ruling on another ground).

7 *See also* Appellant's Br. at 5 ("This was 'experimental surgery' because Dr. Brown had just commenced performance of such procedures, and completed only eight such operations in one year (including Plaintiffs'), before he ceased doing so; and, further, there had been no more than a couple dozen such surgeries ... for neuropathic facial pain 'ever done in the world. None in the United States.' "); J.A. at 192–93 (plaintiff's expert opining that MCSS was "experimental" because "there had only been 21 procedures of motor cortex stimulation procedures for facial pain" in the world and. thus. "[t]his was a procedure that was untried in–in this particular instance or for this particular diagnosis in any great number, so that complications, ultimate outcome generally were unknown"); J.A. at 345–50 (another plaintiff's expert opining that MCSS was "experimental" because the literature identified "only 21 patients who are similar to [the plaintiffs'] and because 'we really don't know the long term effects' " of the procedure).

Conversely, the admission of the testimony would have created a substantial danger of unfair prejudice and of confusion of issues and would have engendered undue delay. The defendants would have been compelled to respond with evidence that the surgeries were successful, generating a series of "mini-trials" on the adequacy of Brown's treatment of his other patients. Presented with this evidence, the jury may well have fastened on ancillary issues or have considered the testimony of the other patients for improper purposes (*e.g.*, it may have punished Brown for his negligence in treating the other patients). And, unquestionably, the proceedings would have been prolonged significantly–just to allow for the introduction of evidence of dubious value. In short, the probative value of the testimony was substantially outweighed by the factors favoring exclusion, and the evidence was properly excluded under Fed.R.Evid. 403.

**8 Additionally, assuming *arguendo* that the district court abused its discretion in excluding the testimony, the plaintiffs have not demonstrated prejudice. As discussed *supra,* the testimony added little, if anything, to the testimony of plaintiffs' experts that MCSS was "experimental" because the procedure had been performed only 21 times (each time outside of the United States) prior to Brown's foray into the area. *See City of Cleveland v. Cleveland Elec. Illuminating Co.*, 734 F.2d 1157, 1164 (6th Cir.1984) (finding an absence of prejudice given "the merely cumulative impact" of the proffered evidence).

*3. The Admission of the Gothro Videotape.*

**[3]** The district court's admission of the Gothro videotape does not constitute grounds for a new trial, as the plaintiffs have not shown prejudice from the admission of the videotape. This court reviews "the district court's evidentiary decisions for abuse of discretion, and we will reverse only when we find that such abuse of discretion has caused more than harmless ***394** error." *Cooley v. Carmike Cinemas, Inc.*, 25 F.3d 1325, 1330 (6th Cir.1994) (internal quotation omitted).

In *Erskine v. Consol. Rail Corp.*, 814 F.2d 266 (6th Cir.1987), this Court discussed the admission of "surprise" evidence:

> One of the primary objectives of the discovery provisions embodied by the

> Federal Rules of Civil Procedure is elimination of surprise in civil trials. *Davis v. Marathon Oil Co.,* 528 F.2d 395, 404 (6th Cir.1975), *cert. denied,* 429 U.S. 823, 97 S.Ct. 75, 50 L.Ed.2d 85. 429 U.S. 823, 97 S.Ct. 75, 50 L.Ed.2d 85 (1976); *Nutt v. Black Hills Stage Lines, Inc.,* 452 F.2d 480, 483 (8th Cir.1971). "[T]rial by ambush is not contemplated by the Federal Rules of Civil Procedure." *Woods v. International Harvester Co.,* 697 F.2d 635, 639 (5th Cir.1983). Nevertheless, a new trial will not be granted on the ground that surprise evidence was admitted unless the moving party was prejudiced. *See, e.g., DeBenedetto v. Goodyear Tire & Rubber Co.,* 754 F.2d 512, 518 (4th Cir.1985); *Saltzman v. Fullerton Metals Co.,* 661 F.2d 647, 651–52 (7th Cir.1981); *Caisson Corp. v. Ingersoll–Rand Co.,* 622 F.2d 672, 682–85 (3d Cir.1980). In order to prevail on his motion for a new trial, plaintiff must show that he was prejudiced and that failure to grant a new trial is inconsistent with substantial justice. *Saltzman,* 661 F.2d at 650–52; 28 U.S.C. § 2111.

*Id.* at 272.

The videotape, which runs approximately two minutes, shows Gothro being interviewed by Brown about the (then-positive) results of her surgery.[8] Gothro described her condition prior to the surgery, and she reported that, following the surgery. 85% of her pain was "gone" (90% when her pulse generator was on). She stated that, prior to the surgery, "[her] whole life revolved around the pain." but that she now "can forget about [her pain]." She revealed that, given her recovery, she was considering returning to work and to school. When asked whether she would have the surgery again, she responded that, although it was "a difficult decision" to have the surgery because it was "really rough" on her, she would.

8 The parties were not able to say when the videotape was recorded. Brown testified that the videotape was recorded on March 6, 1998. or on November 12, 1998. Gothro testified that the videotape was recorded between six weeks and a couple of months after the procedure was completed.

**9 Plaintiffs' counsel did not receive the videotape from defense counsel until a point during trial, despite prior requests for it by plaintiffs' counsel. Defense counsel had mailed a copy of the videotape to plaintiffs' counsel the week before trial, but it did not arrive at his office in Michigan until after he had departed for trial in Ohio.[9] Defense counsel advised the district court that Brown had just located the videotape, explaining that "when Dr. Brown left [APMCO] things were left at [APMCO]. He didn't know where things were et cetera, et cetera, and it was a matter of trying to find it among a lot of different things." J.A. at 306.

9 Apparently, however, plaintiffs' counsel received a transcript of the videotape the week before trial, prior to leaving for Ohio. J.A. at 303.

The district court overruled the plaintiffs' objection to the admission of the videotape, noting that the plaintiffs had made untimely disclosures as well. Specifically, the court stated

> I'll tell you what I'm going to do. I'm going to make

> this real simple. I'm *395 going to let this tape in. and these two witnesses, I mean Jankowski and whatever [former MCSS patients of Brown], or I'm going to keep them both out. It's up to you guys. Sauce for the goose, sauce for the gander. It's the same deal as far as I'm concerned. It's stuff that should have been produced long ago by the both of you.

J.A. at 307. [10]

10 *See also* J.A. at 311 ("All of it should have been produced earlier. I really don't think anybody is being hurt by these problems in late production."); J.A. at 310 ("Well, the point I was making was basically I'm going to let you both use both these things because I think that they are both probative, and all I'm saying is that they should have both been produced sooner, but this having come up now, I'm not going to throw them both out.").

On appeal, the plaintiffs claim that they were prejudiced by the late production and admission of the videotape. Specifically, they contend that they

> had no opportunity to prepare Ms. Gothro to meet the contents of the tape, to explain the same, and to demonstrate to the jury that the tape was taken during the brief few months just after surgery when Ms. Gothro was experiencing some, temporary relief from her prior, facial pain.

Appellants' Br. at 45. [11]

11 Plantiffs' counsel received the videotape (via hand-delivery from defense counsel) a day or two prior to Gothro's testimony. J.A. at 302.

Despite their protestations, the plaintiffs have not shown that they were prejudiced by the admission of the videotape, as required for a new trial. First, Gothro conceded that she experienced some temporary relief from her pain following the procedure. [12] To the extent that the videotape contradicted Gothro's testimony, it went primarily to the issue of damages–namely, the duration and the extent of the pain relief–which the jury never reached. Second, the plaintiffs have not explained why they required additional preparation time or how Gothro's testimony would have differed if they had received the videotape earlier. Gothro admitted that the videotape was an accurate recording of what she said at the time (J.A. at 424). and she testified that the videotape was made approximately 6 weeks after her surgery–during the period when she admitted experiencing relief from pain. J.A. at 428. Third, the district court admitted the videotape in part because the plaintiffs had also made untimely disclosures (namely, the identification of certain fact witnesses), a move well-within its discretion. [13]

12 *See, e.g.*, J.A. at 378 ("It helped for a few months, but eventually everything started tapering off until I was receiving no help from it whatsoever."); J.A. at 334 ("Several months I had pain relief, but after that, it started going away and I was receiving no pain relief from it at all.").

13 The plaintiffs also complain that the videotape was so inaudible that a transcript was necessary, a transcript prepared by the defense. Appellants' Br. at 44. However, the plaintiffs do not identify any errors in the transcription or explain how they were prejudiced by the transcription (apart from the late production of the videotape itself).

In short, the district court did not abuse its discretion by admitting the videotape.

*4. Defendants' Cross–Appeal.*

**10 Given the court's disposition of the plaintiffs' appeal, the defendants' cross-appeal is moot, and the court will not address the merits.

## CONCLUSION

For the foregoing reasons, we AFFIRM the judgment of the district court.

## All Citations

91 Fed.Appx. 384, 2004 WL 68540

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# EXHIBIT G

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UNPUBLISHED OPINION. CHECK
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UNPUBLISHED
Court of Appeals of Michigan.

Harvey GROESBECK, guardian
of Loretta Groesbeck, a protected
person,, Plaintiff–Appellee,
v.
HENRY FORD HEALTH SYSTEM,
d/b/a Henry Ford Bi–County
Hospital, d/b/a Henry Ford Macomb
Hospital, d/b/a Detroit Osteopathic
Hospital, Defendant–Appellant.

Docket No. 307069.
|
Feb. 26, 2013.

Macomb Circuit Court; LC No.2009–003523–NO.

Before: HOEKSTRA, P.J., and K.F. KELLY and BECKERING, JJ.

**Opinion**

PER CURIAM.

***1** Defendant appeals by leave granted from an order denying its motion for partial summary disposition. The trial court held that plaintiff could pursue a claim based on ordinary negligence rather than medical malpractice and that the finder of fact could decide the case based upon a theory of res ipsa loquitur. We reverse.

## I. BASIC FACTS

Plaintiff sued defendant for injuries suffered by 86–year–old Loretta Groesbeck when she fell while undergoing rehabilitation treatment in defendant's hospital on February 1, 2007. On the day in question Loretta was being treated by Esther Karunakar, a licensed physical therapist. Loretta had suffered a minor stroke and Karunakar was to evaluate Loretta's condition and determine the appropriate course of physical therapy to help her stand and walk. Karunakar first saw Loretta on the morning of February 1, 2007. At that first meeting Loretta was too dizzy to undergo the physical therapy evaluation. Karunakar returned to visit Loretta later that afternoon. Loretta felt improved, so Karunakar proceeded with the evaluation. Karunakar assessed Loretta's mobility by having her stand, move to a wheelchair, then operate the wheelchair to move down a hallway. Finally Karunakar assessed Loretta's gait by having her stand up and walk a few steps with the assistance of a gait belt[1] and pyramid walker. Loretta began walking with the assistance of the walker. Karunakar followed behind Loretta, holding the gait belt with one hand and the wheelchair with the other. After taking three steps Loretta collapsed and fell, striking her head.

  

1 The gait belt goes around the patient's waist and is held by the therapist, who is ready to provide support if necessary.

Plaintiff filed his complaint against defendant on July 1, 2009. Plaintiff's complaint was preceded by a Notice of Intent. Count I of plaintiff's complaint alleged a claim for ordinary negligence, asserting that defendant's employees failed to exercise reasonable care and caution in connection with the physical therapy session by allowing Loretta to stand and walk and by failing to secure or hold her to prevent her from falling while she attempted to walk. Count II of plaintiff's complaint raised an alternative claim of medical malpractice based on the same alleged negligence. Count IV of the complaint asserted a claim for negligence based on a theory of res ipsa loquitur, alleging that Loretta's injury was of a kind which does not ordinarily occur without negligence, that defendant had exclusive control over Loretta and the surrounding area, and that any possible explanation as to why she was allowed to fall would be accessible to defendant rather than to plaintiff.

Plaintiff's complaint was accompanied by affidavits of merit signed by physical therapist expert Leonard Elbaum, who opined that Karunakar breached the standard of care for physical therapists by not adequately evaluating her patient's condition and by failing to properly secure or hold Loretta to prevent her from falling while attempting to walk. Elbaum reiterated this opinion in his deposition testimony, maintaining that Karunakar's actions in evaluating Loretta fell below the standard of care applicable to licensed physical therapists by failing to recognize that her patient was at great risk for falling and that Karunakar violated the standard of care by failing to adequately guard Loretta against falling. Plaintiff's second physical therapy expert, Paul Roubal, believed that Karunakar committed an error in professional judgment by immediately starting gait evaluation or training for Loretta following an initial evaluation which showed that she suffered from poor standing balance. At deposition Dr. Elbaum admitted that falls can occur in the course of physical therapy during gait training or assessment even where the physical therapist has not violated the standard of care. Elbaum testified that the fact that a patient fell did not mean that the physical therapist violated the standard of care and that "[i]t's possible you can do the very best you can and still have someone injure themselves during a fall...."

*2 Defendant moved for partial summary disposition pursuant to MCR 2 .116(C) (8) and (10), asking the court to dismiss plaintiff's claim for ordinary negligence and claim for negligence brought under the theory of res ipsa loquitur. Defendant argued that there was no genuine issue of material fact that plaintiff's negligence claims called into question the professional standards for physical therapists and the decision-making of physical therapist Esther Karunakar. Defendant maintained that when and whether to have an impaired patient try to walk was a matter of medical judgment to be exercised by the professional therapist. Defendant argued that the applicable standards and their application

were well beyond the understanding of ordinary laymen and, accordingly, the claim was one for medical malpractice rather than ordinary negligence.

In response, plaintiff's counsel characterized the matter as one of common knowledge or common sense rather than involving trained or professional judgment, arguing "How medically trained do you have to be to know that you're not supposed to let her fall; that you have to hold her?" and that one did not have to be an expert to know that "if you're holding a patient in your arms, you can't drop her." Plaintiff argued that a jury could easily understand the theory of negligence involved without expert testimony.

In denying defendant's motion, the trial court cited this Court's unpublished opinion in *Sheridan v. West Bloomfield Nursing Ctr,* unpublished opinion per curiam of the Court of Appeals, issued March 6, 2007 (Docket No. 272205). The trial court concluded that plaintiff's claim was within the common knowledge and experience of an ordinary juror and did not require expert testimony concerning the exercise of medical judgment:

> This Court is convinced that, as an ordinary person would be, that as a matter of common sense, that if you are helping a five-foot-two-inch, one-hundred four-pound, eighty-six-year-old woman, experiencing dizzy spells and dizziness, and you're helping her to walk, you should hold on carefully or get further assistance. Such is the matter clearly within the realm of common knowledge and experience when dealing with persons in such a condition.

The trial court also denied summary disposition of plaintiff's res ipsa loquitur theory, explaining as follows:

> The elements, as we've just gone over res ipsa loquitur are that it doesn't usually absent someone's negligence; that it's caused by agency within the defendant's control; that it's not due to the plaintiff's actions; and, four, evidence of true—of the true explanation of the event must be more readily accessible to the defendant than to the plaintiff.
>
> The injury in this case did not result from a medical procedure. It is not contested that it resulted from a fall. The fall came as the therapist was helping plaintiff up or helping her to walk or asking her to walk, but in some way directing her and controlling her. The plaintiff's statement was that she was quote/unquote "dropped". Whether dropped or fell, it is within the ordinary sense and common knowledge that an elderly person who is suffering continuous dizziness needs full assistance to get up and to ambulate. The injury in this case would not ordinarily occur in such a circumstance, but for some negligence. This issue can be determined by a jury without expert testimony.

  

*3 The trial court denied defendant's motion in an order issued September 27, 2011, and subsequently denied defendant's motion for reconsideration. On December 15, 2011, this Court granted defendant's application for leave to appeal, but denied its motion for peremptory reversal. *Groesbeck v. Henry Ford Health Sys,* unpublished order of the Court of Appeals, entered December 15, 2011 (Docket No. 307069). [2]

2 The Michigan Supreme Court denied defendant's application for leave to appeal from this Court's order. *Groesbeck v. Henry Ford Health Sys.*, 491 Mich. 855, 809 N.W.2d 147 (2012).

## II. STANDARDS OF REVIEW

This Court reviews de novo a trial court's decision on a motion for summary disposition. *Maiden v. Rozwood,* 461 Mich. 109, 118, 597 N.W.2d 817 (1999). Summary disposition pursuant to MCR 2.116(C)(8) is appropriate where "[t]he opposing party has failed to state a claim on which relief can be granted." Therefore, a motion for summary disposition under MCR 2.116(C)(8) tests the legal sufficiency of a complaint. *Beaudrie v. Henderson,* 465 Mich. 124, 129, 631 N.W.2d 308 (2001). "The motion should be granted if no factual development could possibly justify recovery." *Id.* In contrast, a motion under MCR 2.116(C)(10) tests the factual sufficiency of a complaint. *Maiden,* 461 Mich. at 120, 597 N.W.2d 817. A reviewing court must consider the affidavits, depositions, admissions, and other documentary evidence submitted by the parties and, viewing that evidence in the light most favorable to the nonmoving party, determine whether there is a genuine issue of material fact for trial. *Id.*

This Court also reviews de novo the proper classification of an action as ordinary negligence or medical malpractice. *Bryant v. Oakpointe Villa Nursing Ctr,* 471 Mich. 411, 419, 684 N.W.2d 864 (2004).

Similarly, this Court reviews de novo whether the doctrine of res ipsa loquitur applies to a particular case. *Jones v. Porretta,* 428 Mich. 132, 154 n. 8, 405 N.W.2d 863 (1987).

## III. ORDINARY NEGLIGENCE VS. MEDICAL MALPRACTICE

Defendant argues that the trial court erred in failing to grant defendant summary disposition on plaintiff's ordinary negligence claim where plaintiff's action was one that clearly involved the exercise of medical judgment. We agree.

Not all injuries that occur in a medical facility at the hands of health care providers sound in medical malpractice. *Bryant,* 471 Mich. at 421, 684 N.W.2d 864. Some injuries are the result of "ordinary negligence," where no medical judgment is exercised. Our Supreme Court has explained how to distinguish a medical malpractice claim from one alleging ordinary negligence:

> A medical malpractice claim is distinguished by two defining characteristics. First, medical malpractice can occur only " 'within the course

> of a professional relationship.' " Second, claims of medical malpractice necessarily "raise questions involving medical judgment." Claims of ordinary negligence, by contrast, "raise issues that are within the common knowledge and experience of the [fact-finder]." Therefore, a court must ask two fundamental questions in determining whether a claim sounds in ordinary negligence or medical malpractice: (1) whether the claim pertains to an action that occurred within the course of a professional relationship; and (2) whether the claim raises questions of medical judgment beyond the realm of common knowledge and experience. If both these questions are answered in the affirmative, the action is subject to the procedural and substantive requirements that govern medical malpractice actions. [*Id.* at 422, 684 N.W.2d 864 (citations omitted).]

***4** There is no dispute that Loretta's injury occurred within the course of a professional relationship. The only issue is whether "the reasonableness of the health care professionals' action can be evaluated by lay jurors, on the basis of their common knowledge and experience, it is ordinary negligence" or whether "the reasonableness of the action can be evaluated by a jury only after having been presented the standards of care pertaining to the medical issue before the jury explained by experts." *Id.* at 423, 684 N.W.2d 864.

In *Bryant,* the plaintiff's decedent was a resident in a nursing home and suffered a myriad of physical ailments. *Id.* at 415, 684 N.W.2d 864. Staff were authorized to employ "various physical restraints" including wedges or bumper pads preventing the decedent from "entangling herself in ... the rails" of her bed. *Id.* at 415–416, 684 N.W.2d 864. Nursing assistants observed that the decedent "was lying in her bed very close to the bed rails and was tangled in her restraining vest, gown, and bed sheets." *Id.* at 416, 684 N.W.2d 864. They untangled her and informed their supervisor that the wedges afforded inadequate protection. *Id.* The following day, the decedent "slipped between the rails of her bed and was in large part out of the bed with the lower half of her body on the floor but her head and neck under the bed side rail and her neck wedged in the gap between the rail and the mattress, thus preventing her from breathing" and she died as a result of positional asphyxiation. *Id.* at 417, 684 N.W.2d 864.

The plaintiff's complaint in *Bryant* alleged that the defendant negligently failed to train staff to properly assess the risk of positional asphyxia, failed to inspect the beds and bed frames to ensure that there was no risk of positional asphyxia, and failed to take steps to protect plaintiff's decedent when she was, in fact, discovered entangled between the bed rails and the mattress the day before her death. *Id.* at 417–418, 684 N.W.2d 864. Our Supreme Court held that the plaintiff's failure to train and failure to inspect claims sounded in medical malpractice. With respect to the plaintiff's claim for failure to adequately train, the *Bryant* Court noted:

> in order to assess the risk of positional

> asphyxiation posed by bed railings, specialized knowledge is generally required, as was notably shown by the deposition testimony of plaintiff's own expert, Dr. Steven Miles. Dr. Miles testified that hospitals may employ a number of different bed rails depending on the needs of a particular patient. Accordingly, the assessment of whether a bed rail creates a risk of entrapment for a patient requires knowledge of that patient's medical history and behavior. It is this particularized knowledge, according to Dr. Miles, that should prompt a treating facility to use the bedding arrangement that best suits a patient's "individualized treatment plan," and to properly train its employees to recognize any risks inherent in that bedding arrangement and to adequately monitor patients to minimize those risks. [*Id.* at 427, 684 N.W.2d 864 (footnotes omitted).]

***5** Similarly, with respect to the plaintiff's failure to inspect claim, the *Bryant* Court noted:

> as demonstrated through the deposition testimony of plaintiff's expert, the risk of asphyxiation posed by a bedding arrangement varies from patient to patient. The restraining mechanisms appropriate for a given patient depend upon that patient's medical history. Thus, restraints such as bed railings are, in the terminology of plaintiff's expert physician, part of a patient's "individualized treatment plan."
>
> The risk assessment at issue in this claim, in our judgment, is beyond the ken of common knowledge, because such an assessment require[s] understanding and consideration of the risks and benefits of using and maintaining a particular set of restraints in light of a patient's medical history and treatment goals. In order to determine then whether defendant has been negligent in assessing the risk posed by Hunt's bedding arrangement, the fact-finder must rely on expert testimony. [*Id.* at 429–430, 684 N.W.2d 864.]

However, the Supreme Court concluded that the plaintiff's claim for failure to take steps to protect the decedent after previously discovering her tangled in her bed sounded in ordinary negligence:

> No expert testimony is necessary to determine whether defendant's employees should have taken *some* sort of corrective action to prevent future harm after learning of the hazard. The fact-

  

> finder can rely on common knowledge and experience in determining whether defendant ought to have made an attempt to reduce a known risk of imminent harm to one of its charges. [*Id.* at 430–431, 684 N.W.2d 864 (emphasis in original).]

In denying defendant's motion for summary disposition, the trial court relied on *Bryant* and an unpublished case—*Sheridan v. West Bloomfield Nursing & Convalescent Ctr.*[3] In *Sheridan,* the plaintiff's complaint alleged that the defendants were negligent when "two nurse assistants dropped plaintiff's decedent while moving her from her bed to a wheelchair using a 'gait belt.' " *Id.* at slip op p. 1. The trial court in *Sheridan* granted the defendants' motion for summary disposition after concluding that the plaintiff's claim sounded in medical malpractice. *Id.* This Court reversed, finding that the issue of "whether, having decided to use and having secured the gait belt, defendants acted reasonably when they failed to maintain a secure grip on plaintiff's decedent and dropped her or allowed her to fall on the floor" was a matter "within the common knowledge and experience of an ordinary juror and [did] not require expert testimony concerning the exercise of medical judgment." *Id.* However, critical to the case at bar, is the following distinction—the plaintiff in *Sheridan* "is not challenging the decision to move the decedent from her bed, the decision to use a gait belt, or the manner in which the gait belt was fastened to her body." Here, plaintiff hastily notes in his appellate brief that the "crux of this lawsuit" is that Karunakar "failed to carefully hold Ms. Groesbeck to prevent her from falling ." However, a clear reading of the complaint belies that notion. Plaintiff plainly takes issue with Karunakar's decision to conduct the gait assessment in the first place.

3 An unpublished opinion "has no precedential force." *Nuculovic v. Hill,* 287 Mich.App. 58, 68, 783 N.W.2d 124 (2010); MCR 7.215(C)(1).

***6** For its part, defendant relies upon *Sturgis Bank & Trust Co. v. Hillsdale Community Health Ctr.,* 268 Mich.App. 484, 708 N.W.2d 453 (2005). In *Sturgis,* the plaintiff was injured when she fell out of her hospital bed. *Id.* at 486, 708 N.W.2d 453. "Plaintiff alleged in the complaint that defendant's nursing staff was negligent in failing to prevent [her] from falling out of her hospital bed, which could have been accomplished by proper monitoring and the use of bedrails, where hospital personnel were aware that [she] was in a physical and mental state that required heightened scrutiny in guarding against such an accident." *Id.* at 486–487, 708 N.W.2d 453. The trial court found that the plaintiff's claim sounded in medical malpractice and this Court agreed:

> It is clear from the deposition testimony that a nursing background and nursing experience are at least somewhat necessary to render a risk assessment and to make a determination regarding which safety or monitoring

> precautions to utilize when faced with a patient who is at risk of falling. While, at first glance, one might believe that medical judgment beyond the realm of common knowledge and experience is not necessary when considering [the plaintiff's] troubled physical and mental state, the question becomes entangled in issues concerning [the plaintiff's] medications, the nature and seriousness of the closed-head injury, the degree of disorientation, and the various methods at a nurse's disposal in confronting a situation where a patient is at risk of falling. The deposition testimony indicates that there are numerous ways in which to address the risk, including the use of bedrails, bed alarms, and restraints, all of which entail some degree of nursing or medical knowledge. Even in regard to bedrails, the evidence reflects that hospital bedrails are not quite as simple as bedrails one might find at home. In sum, we find that, although some matters within the ordinary negligence count might arguably be within the knowledge of a layperson, medical judgment beyond the realm of common knowledge and experience would ultimately serve a role in resolving the allegations contained in this complaint. [*Id.* at 498, 708 N.W.2d 453.]

In *David v. Sternberg,* 272 Mich.App. 377, 726 N.W.2d 89 (2006), the plaintiff suffered injury to her foot following a bunionectomy. She alleged that "defendants failed to properly apply strictures to the leg, ankle, and foot, failed to take steps to relieve pain and loss of circulation, failed to properly train their staffs, failed to respond to plaintiff's complaint of pain, and failed to clean and change the dressing." *Id.* at 383, 726 N.W.2d 89. The trial court determined that the plaintiff's claim sounded in medical malpractice and the plaintiff appealed, arguing that "her claim is not about how the bandage was wrapped, but about defendants' failure to take corrective action despite plaintiff's complaints of pain and fever." *Id.* She cited the deposition testimony of her expert, who testified that "it is within the common knowledge of a layperson that these types of complaints indicate a cutoff in blood supply and require removal of the bandage." *Id.* This Court found that, regardless of how the plaintiff attempted to couch her claims, her claims sounded in medical malpractice because they raised questions of medical judgment:

  

> infection, capillary flow, and the postsurgical condition of plaintiff's surgical site and identifying and treating plaintiff's medical condition are not within the realm of common knowledge....This is different from the *Bryant* case, in which the action the defendant failed to take was simply untangling the plaintiff from bedsheets. Because plaintiff's allegations in this case raise questions involving medical judgment, her claim sounds in medical malpractice, not ordinary negligence. [*Id.* at 384, 726 N.W.2d 89.]

*7 According to defendant Charlanne Bratton's deposition testimony, plaintiff underwent surgery on her foot on February 15, 2002. On February 18, 2002, Dr. Bratton removed the outer layers of the surgical dressing and decided not to reapply certain parts of the dressing. On February 22, 2002, Dr. Bratton removed all the layers of the dressing and reapplied some layers more loosely. X-rays were also taken and read at this time. Dr. Bratton assessed plaintiff's condition and determined there was no infection or abnormal microbial growth. On February 25, 2002, Dr. Bratton removed all the dressing and reapplied some layers. At each of these visits, Dr. Bratton determined that there was appropriate capillary fill in the toes and no signs of infection. In all these visits, Dr. Bratton exercised medical judgment in evaluating plaintiff's condition and deciding how to treat her. On the basis of plaintiff's complaint and the record evidence, we conclude that discerning

Here, just as in *Sturgis* and *David,* plaintiff's claims raise questions involving the medical or professional judgment. There are two issues at play: 1) whether Karunakar adequately assessed Loretta's physical abilities before testing her ability to walk; and, 2) whether Karunakar took adequate or reasonable precautions to prevent Loretta from falling during the assessment. While an ordinary layman may know that an elderly patient with impaired balance may fall, he is not likely to know when it is proper to assess that person's gait or what precautions to take to limit the risk of falling. It takes medical knowledge and judgment beyond the realm of common knowledge and experience to determine whether the assessment should have been

performed and what precautions should have been taken to prevent Loretta from falling under the circumstances presented. One need only look to plaintiff's complaint and the testimony of her experts to see that the action clearly sounds in medical malpractice.

The ordinary negligence claim in plaintiff's complaint provided, in relevant part:

> a. Negligently allowed LORETTA GROESBECK to ambulate or walk, which a reasonably careful person would not do where LORETTA GROESBECK required two-person assisted showers;
>
> b. Negligently allowed LORETTA GROESBECK to ambulate or walk, which a reasonably careful person would not do where LORETTA GROESBECK required a seatbelt while in a wheelchair for safety;
>
> c. Negligently allowed LORETTA GROESBECK to ambulate or walk, which a reasonably careful person would not do where LORETTA GROESBECK had a problem with bed mobility and positioning;
>
> ***8** d. Negligently allowed LORETTA GROESBECK to ambulate or walk, which a reasonably careful person would not do where LORETTA GROESBECK had balance deficits;
>
> e. Negligently allowed LORETTA GROESBECK to ambulate or walk, which a reasonably careful person would not do where LORETTA GROESBECK had abnormal mobility;
>
> f. Negligently allowed LORETTA GROESBECK to ambulate or walk, which a reasonably careful person would not do where LORETTA GROESBECK was complaining of being dizzy on February 1, 2007, and was having a problem with dizziness;
>
> g. Negligently failed to recognize that allowing a person in LORETTA GROESBECK'S condition to walk was simply unsafe and dangerous, which a reasonably careful person would have recognized;
>
> h. Negligently failed to secure or hold LORETTA GROESBECK while she was allowed to walk or ambulate, so as to prevent her from falling, where a reasonably careful person would have secured or held her under such circumstances;
>
> i. Negligently failed to catch or assist LORETTA GROESBECK when she became dizzy and was falling, and/or negligently failed to be in a close enough position to catch or assist her when she began to fall, where a reasonably careful person would have caught or assisted her, and would have been in a position to catch or assist her, under such circumstances.
>
> j. Negligently failed to obtain further help or assistance from additional persons or staff to assist in the subject event, where a reasonably careful person would have sought such additional help or assistance.

In addition, plaintiff's experts testified that Karunakar's actions involved medical judgment. Leonard Elbaum testified that he did not necessarily take issue with Karunakar's decision to perform the gait assessment, but that Karunakar was negligent in executing the assessment. Conversely, Paul Roubal took issue with Karunakar's decision to even conduct a gait assessment:

> *A.* Because I felt as though the therapist, after she finished the evaluation and had come up with a poor to fair sitting balance and then a, very simply, poor standing balance, that it was inappropriate for her to initiate gait training on that day when she had at least a two week window to work towards that and that was one of the recommendations by the physiatrist.
>
> *Q.* Ms. Karunakar did not violate the standard of care in her evaluation, is that fair?
>
> *A.* Not from what I could see in the evaluation, no.
>
> *Q.* Okay. And what you're—if I understand what you're saying, it is her exercise of her judgment in implementing gait training based upon the evaluation?
>
> *A.* Yes, sir.

Again, while a juror might have some basic knowledge that a certain degree of care would be needed in dealing with an elderly, infirm patient with balance issues, Karunakar utilized her medical or professional judgment in assessing Loretta and in implementing the gait evaluation, causing it to fall within the definition of medical malpractice, not ordinary negligence. Plaintiff's own experts testified that Karunakar exercised professional medical judgment (improvidently or not) in determining whether to perform a gait assessment and in executing the gait assessment. There is simply no way for plaintiff to avoid the conclusion that the claims sound in medical malpractice, regardless of artful wording and argument. Accordingly, the trial court clearly erred in failing to grant defendant summary disposition on plaintiff's ordinary negligence claim.

## IV. RES IPSA LOQUITUR

***9** Defendant next argues that the trial court erred in denying defendant summary disposition on plaintiff's res ipsa loquitur claim. We agree.

Proof of negligent conduct can be established by a permissible inference of negligence from circumstantial evidence. To invoke the doctrine of res ipsa loquitur, a plaintiff must show: (1) that the event was of a kind that ordinarily does not occur in the absence of negligence; (2) that it was caused by an agency or instrumentality within the exclusive control of the defendant; (3) that it was not due to any voluntary action of the plaintiff; and (4) that evidence of the true explanation of the event was more readily accessible to the defendant than to the plaintiff. *Woodard v. Custer,* 473 Mich. 1, 6–7, 702 N.W.2d 522 (2005). "[I]f a medical

  

malpractice case satisfies the requirements of the doctrine of res ipsa loquitur, then such case may proceed to the jury without expert testimony." *Id.* at 6, 702 N.W.2d 522.

Plaintiff's own expert Leonard Elbaum admitted that physical therapy patients can fall during gait assessment or gait training without any negligence being committed by the physical therapist. The fact that a patient falls during gait assessment did not mean that the therapist violated the standard of care. Elbaum testified:

> *Q.* ... Falls do occur during physical therapy, during gait training, during gait assessment?
>
> *A.* Unfortunately they do, yes.
>
> *Q.* And you're not saying that just because somebody falls and injures themselves during a gait assessment and gait training, that that means the therapist violated the standard of care?
>
> *A.* No, I'm certainly not saying that in every instance.
>
> *Q.* Where the use of a gait belt is appropriate in gait training or gait assessment, the idea is that if the patient does lose his or her balance, the therapist can attempt to steady the patient by hands-on contact; correct?
>
> *A.* Yes.

* * *

> *Q.* And unfortunately a physical therapist, under some circumstances, can be using appropriate parameters for guarding, and the patient suddenly falls and unfortunately the fall occurs and the patient can be injured?
>
> *A.* It's possible you can do the very best you can and still have someone injure themselves during a fall, yes.

Therefore, plaintiff is unable to demonstrate that the event was of a kind that ordinarily does not occur in the absence of negligence. Falling could occur in the absence of any negligence and was a potential consequence of receiving physical therapy. In a medical malpractice case, more than an adverse or bad result is required; while an adverse result may be offered to the jury as part of the evidence of negligence, it does not, standing alone, create an issue for the jury. *Jones,* 428 Mich. at 154, 156, 405 N.W.2d 863.

Additionally, the doctrine of res ipsa loquitur "entitles a plaintiff to a permissible inference of negligence from circumstantial evidence ... when the plaintiff is unable to prove the actual occurrence of a negligent act." *Id.* at 150, 405 N.W.2d 863. Res ipsa loquitur permits proof by circumstantial inferences rather than direct evidence. Plaintiff has pointed to a variety of negligent acts or omissions that allegedly caused Loretta to fall. Thus, plaintiff is not trying to avail himself of res ipsa loquitur to permit an inference of negligence when the true cause is unknown, which is the rationale behind the rule. *Id.* Accordingly, the trial court clearly erred in denying defendant's motion for summary disposition as to plaintiff's res ipsa loquitur claim.

***10** Reversed and remanded for further proceedings not inconsistent with this opinion. We do not retain jurisdiction.

BECKERING, J. (concurring in part and dissenting in part).

I concur in part and dissent in part. At the heart of this appeal is whether plaintiff has stated claims that sound in ordinary or medical negligence associated with 86–year–old Loretta Groesbeck's fall while undergoing physical rehabilitation at defendant's facility. Plaintiff claims that physical therapist Esther Karunakar acted negligently in several distinct ways: (1) by allowing Groesbeck to walk for a gait assessment despite her present physical condition, (2) by failing to secure or hold Groesbeck to prevent her from falling as she walked, and (3) by failing to catch or assist Groesbeck when she became dizzy and fell. The majority concludes that plaintiff's claim that Karunakar negligently allowed Groesbeck to walk for a gait assessment sounds in medical malpractice. I agree. The majority further concludes that plaintiff's claims that Karunakar negligently failed to secure or hold Groesbeck and to catch or assist Groesbeck when she became dizzy and fell likewise sound in medical malpractice. I respectfully disagree. Resolution of the issue of whether Karunakar acted reasonably when she failed to hold Groesbeck securely and allowed her to fall onto the floor is within an ordinary juror's common knowledge and experience and, thus, sounds in ordinary negligence.

It is well established that "[t]he fact that an employee of a licensed health care facility was engaging in medical care at the time the alleged negligence occurred means that the plaintiff's claim may *possibly* sound in medical malpractice; it does not mean that the plaintiff's claim *certainly* sounds in medical malpractice." *Bryant v. Oakpointe Villa Nursing Centre, Inc,* 471 Mich. 411, 421, 684 N.W.2d 864 (2004). To determine whether a claim sounds in ordinary negligence or medical malpractice, a court must consider two questions: "(1) whether the claim pertains to an action that occurred within the course of a professional relationship and (2) whether the claim raises questions of medical judgment beyond the realm of common knowledge and experience." *Id* . at 422, 684 N.W.2d 864. If both questions are answered affirmatively, then the claim sounds in medical malpractice. *Id.* "If the reasonableness of the health care professionals' action can be evaluated by lay jurors, on the basis of their common knowledge and experience, it is ordinary negligence." *Id.* at 423, 684 N.W.2d 864.

In *Bryant,* our Supreme Court concluded that a single count of ordinary negligence can contain both ordinary-negligence and medical-malpractice claims. See *id.* at 414, 417–418, 424–432, 684 N.W.2d 864. On the day before the decedent's injury in *Bryant,* nurses discovered the decedent, who had no control over her locomotive skills and, therefore, was at risk for suffocation by positional asphyxia, lying in her bed very close to the bed rails and tangled in her restraining vest, gown, and bed sheets. *Id.*

  

at 415–416, 684 N.W.2d 864. The nurses untangled the decedent and attempted to position bed wedges onto the decedent's bed; however, the bed wedges would not work properly, so the nurses informed their supervisor. *Id.* at 416, 684 N.W.2d 864. The next day, the decedent slipped between the bedrails such that the lower half of her body was on the floor and her neck was wedged between the rail and the mattress, which prevented her from breathing and ultimately caused her death by positional asphyxia. *Id.* at 417, 684 N.W.2d 864. In a single count of ordinary negligence, the plaintiff alleged that the defendant was negligent in four distinct ways:

> ***11** (1) by failing to provide "an accident-free environment" for [the decedent]; (2) by failing to train its Certified Evaluated Nursing Assistants (CENAs) to recognize and counter the risk of positional asphyxiation posed by bed rails; (3) by failing to take adequate corrective measures after finding [the decedent] entangled in her bedding on the day before her asphyxiation; and (4) by failing to inspect plaintiff's bed arrangements to ensure "that the risk of positional asphyxia did not exist for plaintiff's decedent." [*Id.* at 414, 684 N.W.2d 864.]

The Court first concluded that the plaintiff's accident-free-environment claim sounded neither in ordinary negligence nor in medical malpractice but, rather, in strict liability. *Id.* at 425, 684 N.W.2d 864. The Court then concluded that plaintiff's claims for failures to train and inspect sounded in medical malpractice because they required a fact finder to rely on expert testimony where both claims involved a risk assessment of positional asphyxiation posed by bed rails and other restraints, which is beyond the realm of common knowledge. *Id.* at 428–430, 684 N.W.2d 864. However, the Court concluded that the failure-to-take-corrective-measures claim sounded in ordinary negligence. *Id.* at 430, 684 N.W.2d 864. The Court explained,

> No expert testimony is required here in order to determine whether defendant was negligent in failing to respond after its agents noticed that [the decedent] was at risk of asphyxiation. Professional judgment might be implicated if plaintiff alleged that defendant responded inadequately, but, given the substance of plaintiff's allegation in this case, the fact-finder need only determine whether *any* corrective action to reduce the risk of recurrence was taken after defendant's agents noticed that [the decedent] was in peril. [*Id.* at 431, 684 N.W.2d 864.]

The majority discusses *Bryant* at length but, in my view, fails to appreciate that plaintiff's single count of ordinary negligence can and does contain both ordinary-negligence and medical-malpractice claims. More specifically, the majority opines that

> plaintiff hastily notes in his appellate brief that the "crux of this lawsuit" is that Karunakar "failed to carefully hold Ms. Groesbeck to prevent her from falling." However, a clear reading of the complaint belies that notion. Plaintiff plainly takes issue with Karunaker's decision to conduct the gait assessment in the first place.

Although the majority is correct that a clear reading of plaintiff's complaint demonstrates that plaintiff takes issue with Karunaker's decision to conduct the gait assessment, which I conclude as the majority does is a claim sounding in medical malpractice, plaintiff's allegation that Karunakar negligently decided to conduct the gait assessment does not make plaintiff's ordinary-negligence count sound entirely in medical malpractice. See *id.* at 414, 417–418, 424–432, 684 N.W.2d 864. Rather, plaintiff's claims that Karunakar failed to hold Groesbeck securely and allowed her to fall onto the floor must be evaluated separately from plaintiff's claim regarding Karunakar's decision to conduct the gait assessment to determine whether it sounds in medical malpractice or ordinary negligence. See *id.* at 424–425, 684 N.W.2d 864.

***12** In evaluating plaintiff's claims that Karunakar failed to hold Groesbeck securely and allowed her to fall onto the floor, I find instructive this Court's opinion in *Sheridan v. West Bloomfield Nursing & Convalescent Center, Inc,* unpublished opinion per curiam of the Court of Appeals, issued March 6, 2007 (Docket No. 272205). Although *Sheridan* is unpublished and, thus, not binding on this Court, MCR 7.215(C)(1), I consider it to have great persuasive value given its factual similarity to this case, and I would apply this Court's reasoning in *Sheridan* when evaluating plaintiff's claims, see *Paris Meadows, LLC v. City of Kentwood,* 287 Mich.App. 136, 145 n. 3, 783 N.W.2d 133 (2010). In *Sheridan,* the plaintiff alleged that the defendants were negligent "when two nurse assistants dropped plaintiff's decedent while moving her from her bed to a wheel chair using a 'gait belt.' " *Sheridan,* unpub op at 2. The plaintiff did not challenge the defendants' decision to move the decedent, the decision to use a gait belt, or the manner in which the gait belt was fastened to the decedent. *Id.* Rather, the only claim of negligence raised by the plaintiff was whether the defendants, after they decided to use the gait belt and secured the decedent with it, "acted reasonably when they failed to maintain a secure grip on plaintiff's decedent and dropped her or allowed her to fall on the floor." *Id.* This Court concluded that the plaintiff's claim sounded in ordinary negligence, explaining that "[r]esolution of this issue is within the common knowledge and experience of an ordinary juror and does not require expert testimony concerning the exercise of medical judgment." *Id.*

Similar to the plaintiff's claim against the nurse assistants in *Sheridan,* plaintiff's claims in this case are whether Karunakar acted reasonably when she failed to hold Groesbeck securely and allowed her to fall onto the floor. As in *Sheridan,* resolution of these claims is "within the common knowledge and experience of an

ordinary juror and does not require expert testimony concerning the exercise of medical judgment." *Id.* When Groesbeck entered defendant's facility, she was 86 years old, weighed just over 110 pounds, and had just suffered a minor stroke. On the morning of her first day with defendant, she was vomiting, dizzy, and had difficulty standing. Several hours later, she was able to move in a wheelchair and stand for a short period of time. Karunakar then decided to allow Groesbeck to walk with a pyramid walker for a gait assessment. She fastened a gait belt around Groesbeck's waist and held the belt with one hand while dragging a wheelchair in her other hand. After taking three steps, Groesbeck stated that she was dizzy, fell to the floor, and hit her head. Expert testimony is not required for an ordinary juror to determine whether Groesbeck acted negligently by failing to hold Groesbeck securely and allowing her to fall onto the floor. See *id.;* see also *Fogel v. Sinai Hosp. of Detroit,* 2 Mich.App. 99, 101–102, 138 N.W.2d 503 (1965) (claim sounds in ordinary negligence where hospital patient falls while walking to the bathroom with a nurse's assistance); *Gold v. Sinai Hosp. of Detroit, Inc.,* 5 Mich.App. 368, 369–370, 146 N.W.2d 723 (1966) (claim sounds in ordinary negligence where nauseated and dizzy hospital patient falls while being assisted from a seated position onto an examination table by a nurse who braced the patient from behind).

***13** The majority opines that *Sheridan* is distinguishable from the present case in one critical respect: the plaintiff in *Sheridan* was not challenging the decision to move the decedent, the decision to use the gait belt, or the manner in which the gait belt was fastened. I fail to see the critical nature of this distinguishing fact. Indeed, it is irrelevant to whether plaintiff's claims that Karunakar failed to hold Groesbeck securely and allowed her to fall onto the floor sound in medical malpractice or ordinary negligence. As previously discussed, *Bryant* makes clear that a plaintiff's single count of ordinary negligence can contain both ordinary-negligence and medical-malpractice claims. *Bryant,* 471 Mich. at 414, 417–418, 424–432, 684 N.W.2d 864. Thus, plaintiff's claim that Karunakar was negligent by allowing Groesbeck to walk for a gait assessment has no bearing on whether plaintiff's claims that Karunakar failed to hold Groesbeck securely and allowed her to fall onto the floor sound in medical malpractice or ordinary negligence; the claims must be evaluated separately. See *id.* at 424–425, 684 N.W.2d 864.

The majority also opines that plaintiff's claims that Karunakar negligently failed to hold Groesbeck securely and allowed her to fall onto the floor are a claim that Karunakar failed to take "adequate or reasonable precautions to prevent [Groesbeck] from falling during the assessment." According to the majority, Karunakar exercised medical judgment when deciding what precautions to take when allowing Groesbeck to walk, i.e., what guarding method to implement when executing the gait assessment. Thus, the majority concludes that Karunakar's use of knowledge beyond the realm of common knowledge and experience establishes

  

that plaintiff's claims sound in medical malpractice. I agree that a physical therapist exercises medical judgment when deciding what guarding method to implement, including whether a gait belt should be used. And, I also agree that a physical therapist exercises medical judgment when conducting a gait assessment. However, I disagree for several reasons with the majority's conclusion that plaintiff's claims sound in medical malpractice on this basis. First, aside from plaintiff's claim that Karunakar negligently allowed Groesbeck to walk, the remaining claims in plaintiff's ordinary-negligence count raise the same allegation as the plaintiff did in *Sheridan:* negligence by failing to hold a patient securely and allowing the patient to fall. None of the claims in plaintiff's ordinary-negligence count take issue with Karunakar's decision to use the gait belt as a precaution for Groesbeck. Second, plaintiff's claims that Karunakar failed to hold Groesbeck securely and allowed her to fall onto the floor do not sound in medical malpractice simply because Karunakar exercised medical judgment during the gait assessment. Rather, the appropriate inquiry is whether the reasonableness of Karunakar's action can be evaluated by lay jurors on the basis of their common knowledge and experience. See *id.* at 423, 684 N.W.2d 864. The fact that a health-care professional exercises medical judgment when committing a negligent act does not prohibit lay jurors from evaluating on the basis of common knowledge and experience the reasonableness of the health-care professional's action; for example, surgeons certainly exercise medical judgment while performing surgery, but, "if a foreign object is left within the body of a patient on whom an operation has been performed, to his injury, laymen may properly decide the question of negligence without the aid of experts." *Roberts v. Young,* 369 Mich. 133, 138, 119 N.W.2d 627 (1963), citing *Wood v. Vroman,* 226 Mich. 625, 198 N.W. 228 (1924); *LeFaive v. Asselin,* 262 Mich. 443, 247 N.W. 911 (1933); *Taylor v. Milton,* 353 Mich. 421, 92 N.W.2d 57 (1958). Finally, although Karunakar used medical judgment for the gait assessment, lay jurors using common knowledge and experience can determine without expert testimony whether Karunakar acted unreasonably by holding onto Groesbeck—an 86–year–old, 110–pound, first-day-rehabilitation patient who had just suffered a minor stroke and had a history just several hours earlier of vomiting, dizziness, and difficulty standing —with only one hand as Groesbeck walked and by allowing Groesbeck to fall.

***14** For these reasons, I respectfully dissent from the majority's holding that plaintiff's ordinary-negligence count sounds entirely in medical malpractice.

**All Citations**

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# EXHIBIT H

2014 WL 5364119
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UNPUBLISHED OPINION. CHECK
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UNPUBLISHED
Court of Appeals of Michigan.

Shirley VIA, Plaintiff–Appellant,
v.
BEAUMONT HEALTH
SYSTEM, William Beaumont
Hospital Troy, and Amy Joanne
Adams, Defendants–Appellees.

Docket No. 316776.
|
Oct. 21, 2014.

Oakland Circuit Court; LC No.2011–122519–NH.

Before: FITZGERALD, P.J., and WILDER and OWENS, JJ.

**Opinion**

PER CURIAM.

***1** In this medical malpractice case, plaintiff appeals as of right from the trial court's order granting defendants summary disposition under MCR 2.116(C)(10). We affirm.

I

Plaintiff was admitted at defendant hospital on March 17, 2010. On March 22, 2010, during a visit with her husband, plaintiff began coughing up blood, after which she developed trouble breathing. Plaintiff was intubated, suffered cardiac arrest and required cardiopulmonary resuscitation. After she was stabilized, doctors discovered and removed a plastic single-dose pill package with a small amount of foil attached to it from her esophagus. Plaintiff had to remain in intensive care on ventilation for several days after this incident. She testified that she did not recall anything about her hospital stay except she had a vague memory of a nurse telling her to swallow or take "something" out of her mouth.

On the day of the incident, Nurse Amy Joanne Adams had administered six medications in pill form to plaintiff. Each had been individually wrapped. Adams testified that she showed each pill to plaintiff, told her what medication it was, opened the package, and placed the pill in a cup. Adams also testified that, after opening all of the packages, she then gave plaintiff each pill, one at a time, in a spoonful of applesauce since plaintiff had trouble swallowing. Adams stated that right after giving plaintiff the pills, she threw the packages in a trash can under the sink. Adams testified that she did not give plaintiff a plastic pill package. [1]

1 Adams claimed plaintiff's husband was present during the administration of the medications, but her husband denied being present.

Plaintiff alleged in her complaint that the pill package and subsequent intubation caused laceration, ulceration, and severe bleeding, which led to pain and suffering, difficulty

swallowing, and permanent debilitation. Plaintiff further alleged that defendant Adams or another hospital employee administered a pill to plaintiff without removing the packaging. In addition, plaintiff alleged that the standard of care was breached by the failure to administer her medication safely, including removing it from the package, requiring that it be taken while the nurse is watching the patient, and not leaving the packages open at the bedside. Plaintiff's expert, Tracey Christy, signed the affidavit of merit. In the lower court, she asserted several alternative grounds for malpractice: (1) that Adams administered a pill to plaintiff that was packaged, or (2) that Adams or another hospital staff member left an empty pill package in a place where plaintiff could swallow it. Tracey opined that the pill wrapper cut plaintiff's throat and esophagus causing blood to enter her lungs, which ultimately resulted in cardiopulmonary distress due to lack of oxygen. Plaintiff also asserted in the complaint that she has since suffered a reduced ability to ambulate, respiratory problems, and bladder incontinence as a result of the incident, but Christy had not reviewed plaintiff's medical records and did not provide any expert testimony regarding plaintiff's condition and any damages resulting from the incident.

***2** Defendants moved for summary disposition, which the trial court initially denied in part and granted in part. The trial court concluded a question of fact existed regarding causation, but that there was no genuine issue of material fact concerning the issue of permanent and continuing damages from the incident because plaintiff failed to offer any expert testimony to prove those damages. On reconsideration, the trial court also granted defendants' motion for summary disposition as to causation. The trial court stated, "Plaintiff's tenuous causation theory rests on the premise that Defendant Amy Adams, R.N., left a pill package in Plaintiff's room, which Plaintiff then mistakenly swallowed."[2] The trial court went on to discuss "several troubling deficiencies in Plaintiff's causation proofs," which included lack of evidence that Adams left a pill package in the room, lack of evidence that defendants used pill packages similar to the one that injured plaintiff, and lack of evidence that plaintiff was at risk for accidentally swallowing a pill package, as well as the fact that plaintiff's expert had admitted that there was more than one plausible explanation for how the pill package got into plaintiff's throat. Relying on *Skinner v. Square D Co.*, 445 Mich. 153, 165; 516 NW2d 475 (1994), the trial court held that plaintiff had failed to meet her "threshold requirement for presenting evidence that would take her causation theory beyond a mere possibility and show that it was probable."

2 It appears that plaintiff abandoned the theory that Adams had given plaintiff a pill still in its wrapper. The pathology report and Adams's deposition testimony indicated that there was no pill in the wrapper that was removed from plaintiff's throat.

## II

This Court reviews de novo a trial court's decision whether to grant or deny a

motion for summary disposition under MCR 2.116(C)(10). *BC Tile & Marble Co., Inc. v. Multi Bldg. Co., Inc.,* 288 Mich.App 576, 583; 794 NW2d 76 (2010).

> A motion under MCR 2.116(C)(10) tests the factual sufficiency of the complaint. In evaluating a motion for summary disposition brought under this subsection, a trial court considers affidavits, pleadings, depositions, admissions, and other evidence submitted by the parties, MCR 2.116(G)(5), in the light most favorable to the party opposing the motion. Where the proffered evidence fails to establish a genuine issue regarding any material fact, the moving party is entitled to judgment as a matter of law. [*Maiden v. Rozwood,* 461 Mich. 109, 120; 597 NW2d 817 (1999).]

"In presenting a motion for summary disposition, the moving party has the initial burden of supporting its position by affidavits, depositions, admissions, or other documentary evidence. The burden then shifts to the opposing party to establish that a genuine issue of disputed fact exists." *Quinto v. Cross & Peters Co.,* 451 Mich. 358, 362; 547 NW2d 314 (1996) (citations omitted). "Where the burden of proof at trial on a dispositive issue rests on a nonmoving party, the nonmoving party may not rely on mere allegations or denials in pleadings, but must go beyond the pleadings to set forth specific facts showing that a genuine issue of material fact exists." *Id.;* see also MCR 2.116(G)(4). The moving party is entitled to judgment as a matter of law where "the nonmoving party's evidence is insufficient to establish an essential element of the nonmoving party's claim." *Quinto,* 451 Mich. at 362.

***3** In a medical malpractice case, the plaintiff must establish four elements: (1) the applicable standard of care, (2) that the defendant breached that standard of care, (3) that the plaintiff suffered injury, and (4) that the defendant's breach was a proximate cause of the plaintiff's injury. *Locke v. Pachtman,* 446 Mich. 216, 222; 521 NW2d 786 (1994); *Woodard v. Custer,* 473 Mich. 1, 7; 702 NW2d 522 (2005); MCL 600.2912a.

The causation element requires a showing that "but for" defendant's conduct the plaintiff's injury would not have occurred. *Badalamenti v. William Beaumont Hosp–Troy,* 237 Mich.App 278, 285; 602 NW2d 854 (1999). Where the jury would be required to speculate, or the probabilities are at best evenly balanced, judgment as a matter of law in favor of the defendant is required. *Id.* Our Supreme court stated in *Skinner:* [3]

3 Plaintiff argues that *Skinner* is inapplicable because *Skinner* was not a medical malpractice case, but rather a products liability case. This argument lacks merit. Both this Court and the Michigan Supreme Court have applied *Skinner* in the medical malpractice context. See *Ykimoff v. Foote Mem. Hosp.,* 285 Mich.App 80, 88–89; 776 NW2d 114 (2009), and

*O'Neal v. St. John Hosp. & Med. Ctr.*, 487 Mich. 485, 496; 791 NW2d 853 (2010).

> We want to make clear what it means to provide circumstantial evidence that permits a reasonable inference of causation.... [A]t a minimum, a causation theory must have some basis in established fact. However, a basis in only slight evidence is not enough. Nor is it sufficient to submit a causation theory that, while factually supported, is, at best, just as possible as another theory. [*Skinner,* 445 Mich. at 164.]

Plaintiff's two alternative theories—that Adams administered a pill in its packaging and a pill package was left in a place where plaintiff could swallow it—could not take her causation theory out of the realm of mere possibility. First, there is no documentary evidence or witness testimony that Adams gave plaintiff a pill still in its package. Adams's testimony that she had a clear memory of giving plaintiff her pills that morning and did not give plaintiff a pill that was still in its wrapper, stands uncontroverted by contrary evidence. Because plaintiff may not rest on her mere allegations, defendant was entitled to summary disposition on this theory. *Quinto,* 451 Mich. at 362.

Second, the theory that a pill package was left in a place where plaintiff could swallow it is purely speculative and has no basis in established fact. "[A]n expert's opinion is objectionable where it is based on assumptions that are not in accord with the established facts." *Badalamenti,* 237 Mich.App at 286. Even a causation theory based on circumstantial evidence "must have some basis in established fact." *Skinner,* 445 Mich. at 164. Christy averred that leaving medication for plaintiff to self-administer would have been a violation of the standard of care because plaintiff's underlying condition made her confused and, therefore, vulnerable and capable of unwittingly putting things in her mouth. Christy could only opine that a pill package "could have been" left at plaintiff's bedside by one of the nurses. But no evidence demonstrated that this is what actually happened. Rather, according to Adams, she threw all of the empty pill packages in the garbage. Moreover, there were no markings on the plastic single-dose pill package recovered from plaintiff's esophagus that could be used to confirm that it came from defendant hospital or was associated with one of the six medications Adams gave plaintiff. Absent any evidence in the record that is in accord with Christy's opinion, the trial court properly granted defendant's motion for summary disposition regarding this theory.

***4** Plaintiff argues that summary disposition was inappropriate because she should have been allowed to proceed to trial on a theory of res ipsa loquitur. We disagree. Whether the doctrine can be applied to a certain set of facts is a question of law for the court to decide. See *Jones v. Porretta,* 428 Mich. 132, 154 n 8; 405 NW2d 863 (1987).

Plaintiff did not plead res ipsa loquitur in her complaint, and this failure, alone, is fatal to plaintiff's assertion of res ipsa loquitur because "[a] plaintiff's theory in a medical malpractice case must be pleaded

  

with specificity and the proofs must be limited in accordance with the theories pleaded." *Badalamenti,* 237 Mich.App at 284. However, plaintiff's res ipsa loquitur theory also fails on the merits. Under the doctrine of res ipsa loquitur, in certain factual situations, the law will allow a jury to infer negligence from circumstantial evidence in the absence of direct proof. Prosser & Keeton, Torts (5th ed), § 39, p 243. In order to avail herself of the doctrine, plaintiff was required to meet the following conditions:

> (1) the event must be of a kind which ordinarily does not occur in the absence of someone's negligence;
>
> (2) it must be caused by an agency or instrumentality within the exclusive control of the defendant;
>
> (3) it must not have been due to any voluntary action or contribution on the part of the plaintiff; and
>
> (4) [e]vidence of the true explanation of the event must be more readily accessible to the defendant than to the plaintiff. *[Woodard,* 473 Mich. at 7 (citations and internal quotation marks omitted).]

Plaintiff failed to establish any of these conditions.

First, " 'the fact that the injury complained of does not ordinarily occur in the absence of negligence must either be supported by expert testimony or must be within the common understanding of the jury.' " *Woodard,* 473 Mich. at 7, quoting *Locke,* 446 Mich. at 231. Plaintiff's expert did not assert that the type of injury plaintiff suffered does not ordinarily occur without negligence, and because this type of injury does not ordinarily occur at all, it would not have been in the "common understanding of the jury" that the injury would not occur in the absence of negligence. A bad result, alone, is not sufficient to satisfy this condition. *Locke,* 446 Mich. at 230–231.

Second, there is no evidence that the pill package that injured plaintiff was in the exclusive control of defendants. There are no identifying marks linking the pill package to the medication Adams gave plaintiff or any other medication used by the hospital. Moreover, even if the package was left at plaintiff's bedside, as she postulates, it was not in defendants' exclusive control because hospital staff was not present in plaintiff's room at all times, and plaintiff's husband visited and helped take care of plaintiff.

Third, there are no facts in the record to support the theory that plaintiff swallowed the package only and exclusively because Adams administered her medicine, and not as the result of plaintiff's voluntary action. In addition, plaintiff's alternative theory, that the package was improperly left at her bedside, would have necessarily involved plaintiff voluntarily putting the pill package in her mouth after it was left within her reach. Thus, plaintiff cannot establish the third, voluntary action condition.

***5** Fourth, the record does not indicate that the "true explanation of the event" is more readily available to defendants than

  

it is to plaintiff. Plaintiff has the pathology report and the medical records related to the event. Plaintiff and plaintiff's expert examined the pill package. Plaintiff deposed Nurse Adams. There is no indication that any relevant records from the hospital are being withheld or that defendants know the "true explanation," and although plaintiff testified that she remembers very little from the hospital stay when she suffered the injury, her husband was present when she began coughing up blood.

Because the four elements of res ipsa loquitur are not met, plaintiff cannot rely on the doctrine to create an inference of negligence and salvage her claim. [4]

4 In light of this conclusion that the trial court properly granted summary disposition to defendants for lack of sufficient evidence of causation, we decline to address plaintiff's argument that the trial court erred by also granting summary disposition as to the permanent and continuing nature of her damages because plaintiff did not proffer expert testimony to prove these damages. See *Pennington v. Longabaugh*, 271 Mich.App 101, 104; 719 NW2d 616 (2006).

Affirmed. Defendants, as the prevailing parties under MCR 7.219, may tax costs.

## All Citations

Not Reported in N.W.2d, 2014 WL 5364119

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# EXHIBIT I

**HEATHER PULLEY, Plaintiff, vs. THE GILLETTE CO., a Delaware Corp., Defendant.**

**No. 94-CV-70741**

**UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MICHIGAN, SOUTHERN DIVISION**

*1994 U.S. Dist. LEXIS 17659*

**October 13, 1994, Decided**
**October 13, 1994, FILED**

**CASE SUMMARY:**

**PROCEDURAL POSTURE:** Defendant manufacturer filed a motion for summary judgment in plaintiff consumer's action against the manufacturer for injuries sustained while using the manufacturer's product. The consumer alleged design defect, manufacturing defect, failure to warn, and res ipsa loquitur.

**OVERVIEW:** The consumer sustained injuries while using a product made by the manufacturer and brought an action against the manufacturer alleging design defect, manufacturing defect, and res ipsa loquitur. The manufacturer filed a motion for summary judgment. The court granted summary judgment in favor of the manufacturer. The court held: (1) that the consumer failed to show the existence of a defect and failed to show that the manufacturer's design choice was unreasonable, (2) that there was no reasonable basis for inferring that the alleged defect was caused by the manufacturer, and (3) that the consumer did not meet the requirements under res ipsa loquitur because she failed to show that the accident was one that usually does not happen without the negligence of another party, and there was evidence that the manufacturer was not the only party to control the product.

**OUTCOME:** The court granted the manufacturer's motion for summary judgment in the consumer's action against the manufacturer for injuries sustained while using the manufacturer's product.

**LexisNexis(R) Headnotes**

***Business & Corporate Law > Agency Relationships > Establishment > Proof of Agency > General Overview***
***Torts > Products Liability > Design Defects***
***Torts > Products Liability > Manufacturing Defects***
[HN1] Under the Erie doctrine, the substantive law of the forum state is applied in diversity cases. According to Michigan law, in a products liability action, as to either manufacturing or design defect, the plaintiff carries the burden of showing the defect, a causal relationship between the defect and the plaintiff's damage, and that the defect was attributable to the manufacturer. If the plaintiff cannot satisfy all three prongs of this test, summary judgment is appropriate. Similarly, if plaintiff seeks to apply the res ipsa loquitur doctrine she must show the following: (1) the event must be of the kind which ordinarily does not occur in the absence of someone's negligence; (2) it must be of an agency or instrumentality within the exclusive control or the

defendant; (3) it must not have been due to any voluntary action or contribution on the part of the plaintiff; (4) evidence of the true explanation of the event must be more readily accessible to the defendant than to the plaintiff. If the plaintiff cannot meet all of these requirements there is an absence of a genuine issue of material fact.

***Civil Procedure > Federal & State Interrelationships > Erie Doctrine***
***Civil Procedure > Summary Judgment > Burdens of Production & Proof > General Overview***
***Civil Procedure > Summary Judgment > Motions for Summary Judgment > General Overview***
[HN2] The Federal Rules of Civil Procedure govern procedural matters in diversity cases. Thus, federal standards govern the grant of summary judgment. The plain language of *Fed. R. Civ. P. 56(c)* mandates the entry of summary judgment, after adequate time for discovery and upon motion, against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial. In such a situation, there can be no genuine issue as to any material fact since, a complete failure of proof concerning an essential element of the nonmoving party's case necessarily renders all other facts immaterial.

***Torts > Products Liability > Design Defects***
***Torts > Products Liability > Negligence***
[HN3] When a design defect is alleged, Michigan courts use a pure negligence, risk-utility test to determine whether the manufacturer should be held liable. The competing factors to be weighed under a risk-utility balancing test invite the trier of fact to consider the alternatives and risks faced by the manufacturer and to determine whether in light of these the manufacturer exercised reasonable care in making the design choices it made. Simply put, if the design choice was not unreasonable a design defect does not exist.

***Civil Procedure > Summary Judgment > Standards > General Overview***
***Torts > Products Liability > Manufacturing Defects***
***Torts > Products Liability > Strict Liability***
[HN4] Plaintiff sustains her burden in a manufacturing defect action if she establishes with direct or circumstantial evidence a reasonable probability that the manufacturing defect is attributable to the manufacturer. She is not, however, obliged to eliminate all possible causes of the accident consistent with the view that there was a manufacturing defect. But the plaintiff must establish a logical sequence of cause and effect, notwithstanding the fact that other plausible theories may have factual support. On a motion for summary disposition the question is whether it is reasonable to infer that the accident was probably caused by a defect attributable to the manufacturer.

***Torts > Negligence > Proof > Evidence > Circumstantial & Direct Evidence***
***Torts > Negligence > Proof > Res Ipsa Loquitur > Evidentiary Effect***
[HN5] Alleging a res ipsa loquitur claim only means that the plaintiff is entitled to a permissible inference of negligence from circumstantial evidence. Mere injury does not impute negligence upon anyone. It only presents an opportunity to grasp the res ipsa loquitur lifeline.

**JUDGES:** [*1] John Feikens, United States District Judge

**OPINION BY:** John Feikens

**OPINION**

**OPINION**

**I. *Background***

The event which precipitated this action happened on February 9, 1993. On that date Heather Pulley (Pulley or Plaintiff) severely cut her leg while shaving with a Gillette Daisy Plus disposable razor manufactured by the Gillette Co. (Gillette or Defendant). According to Pulley the mishap occurred when a piece of plastic holding the razor fell off and exposed the blade. [1] The blade then curled inward inflicting a gash on Pulley's right leg which required thirty stitches to close. Shortly after the accident Pulley filed suit against Defendant in Wayne County Circuit Court. In her complaint Pulley alleged that there was a defect in the design or manufacture of the razor and that Defendant failed to warn her of the possible dangers when us jag the product. Citing federal court diversity jurisdiction, Defendant removed this case to this Court on February 25, 1994. Discovery was closed on July 31, 1994.

1 The piece of plastic is unavailable because it fell down the drain.

[*2] On August 29, 1994 Gillette submitted a motion for summary judgment pursuant to *Fed. R. Civ. P. 56(c)*. In that motion Gillette argues that there is no genuine issue of material fact concerning Plaintiff's design defect, manufacturing defect or failure to warn claims. Defendant also argues that *res ipsa loquitur* is inapplicable. I agree with Gillette and will grant summary judgment.

II. *Law and Analysis*

[HN1] Under the *Erie* doctrine, the substantive law of the forum state is applied in diversity cases. *Erie R.R. Co, v. Tompkins, 304 U.S. 64, 82 L. Ed. 1188, 58 S. Ct. 817 (1938)*. According to Michigan law, in a products liability action, as to either manufacturing or design defect, the plaintiff carries the burden of showing the defect, a causal relationship between the defect and the plaintiff's damage, and that the defect was attributable to the manufacturer. *Skinner v. Square D Co., 445 Mich. 153, 516 N.W.2d 475 (1994)*; *Mulholland v. DEC Int'l, 432 Mich. 395, 443 N.W.2d 340 (1989)*. If the plaintiff cannot satisfy all three [*3] prongs of this test, summary judgment is appropriate. *Id.* Similarly, since Plaintiff seeks to apply the *res ipsa loguitur* doctrine she must show the following:

> (1) the event must be of the kind which ordinarily does not occur in the absence of someone's negligence;
>
> (2) it must be of an agency or instrumentality within the exclusive control or the defendant;
>
> (3) it must not have been due to any voluntary action or contribution on the part of the plaintiff;(4) evidence of the true explanation of the event must be more readily accessible to the defendant than to the plaintiff. *Jones v. Porretta, 428 Mich. 132, 405 N.W.2d 863 (1987)*.

If Plaintiff cannot meet all of these requirements there is an absence of a genuine issue of material fact.

[HN2] The Federal Rules of Civil Procedure govern procedural matters in diversity cases. *Hanna v. Plumer, 380 U.S. 460, 14 L. Ed. 2d 8, 85 S. Ct. 1136 (1965)*. Thus, federal standards govern the grant of summary judgment. In *Celotex v. Catrett, 477 U.S. 317, 91 L. Ed. 2d 265, 106 S. Ct. 2548 (1986)*, [*4] the United States Supreme Court stated the standard for summary judgment. The Court stated:

> "The plain language of *Rule 56(c)* mandates the entry of summary judgment, after adequate time for discovery and upon Motion, against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial. In such a Situation, there can be no genuine issue as to any material fact since, a complete failure of proof concerning an essential element of the nonmoving party's case necessarily renders all other facts immaterial.

*Id. at 321*. In this case discovery is closed. Defendant has submitted a motion, delineating its position that Plaintiff cannot establish the existence of basic elements on which she has the burden of proof at trial, to which Plaintiff has responded. After reviewing the papers, and having heard oral argument, it is clear to me that Plaintiff cannot show a design defect, that a manufacturing defect is attributable to Defendant or that this is a proper case for *res ipsa loquitur*. Thus, summary judgment [*5] is appropriate.

A. *Plaintiff's Design Defect Claim*

Plaintiff alleges that a design defect caused her injury. To sustain this claim she must first show the existence of a defect. She has failed to do so.

[HN3] When a design defect is alleged, Michigan courts use a "pure negligence', risk-utility test to determine whether the manufacturer should be held liable. The court in *Prentis v. Yale Mfg.* stated:

> The competing factors to be weighed under a risk-utility balancing test invite the trier of fact to consider the alternatives and risks faced by the manufacturer and to determine whether in light of these the manufacturer exercised reasonable care in making the design choices it made.

*421 Mich. 670, 688.* Simply put, if the design choice was not unreasonable a design defect does not exist.

Plaintiff's response does not address whether Defendant's design choice was ill-considered. Her allegations are limited to several cryptic statements which suggest that the razor head might be susceptible to damage by certain chemicals and that another product manufactured by Defendant is of a better design.

These statements do not support Plaintiff's claim that Defendant's [*6] choice of design was unreasonable. It is common knowledge that many manufactured products might be susceptible to damage by chemicals; that fact does not make Defendant's design choice unreasonable. Also, the fact that Defendant makes another product with a different design is not helpful to Plaintiff's theory. Assuming the other product is safer, the claimed offending razor might be easier to use or less expensive or more efficient. In other words, even if the razor is dangerous, the design choice is not necessarily unreasonable. Because Pulley cannot show that Gillette's design choice was unreasonable, she cannot show that the razor is defectively designed.

B. *Plaintiff's Manufacturing Defect Claim*

Pulley's manufacturing defect claim must also fail because she did not submit any evidence to demonstrate a defect, or that if one exists, it is attributable to the manufacturer. [2] *Skinner, 445 Mich. at 159.* [HN4] Plaintiff sustains her burden if she "establishes with direct or circumstantial evidence a reasonable probability that the manufacturing defect is attributable to the manufacturer." *Holloway v. General Motors (Reh'g,), 403 Mich. 614, 621, 271 N.W.2d 777 (1978).* [*7] She "is not, however, obliged to eliminate all possible causes of the accident consistent with the view that there was a manufacturing defect." *Id.* But the plaintiff must establish a logical sequence of cause and effect, notwithstanding the fact that other plausible theories may have factual support. *Mulholland v. DEC Int'l, 432 Mich. 395, 443 N.W.2d 340 (1989).* On a motion for summary disposition the question is whether it is reasonable to infer that the accident was probably caused by a defect attributable to the manufacturer. *Holloway,* 403 Mich. at 602.

> 2 The fact that Plaintiff failed to produce an expert, who would state how such an accident occurred, indicates that it is unlikely that Pulley can establish causation.

In *Holloway,* the issue was whether the ball joint assembly on a plaintiff's car cracked prior to or after the accident which killed the decedent. *Id.* Both parties agreed that the break was fresh, clean and due [*8] to impact failure. This meant the defect was probably latent and not due to fatigue, wear, improper repair or prior misuse. The defendant's experts testified that there were no signs of fatigue or wear. *Id. at 627.* In addition, the defendant's attorney, when asked to single cut causes for the accident, gave three alternatives, all of which were attributable to the defendant. *Id. at 628.* This circumstancial evidence convinced the court that plaintiff met his burden of showing that the defect was possibly attributable to defendant, even though plaintiff did not produce an expert to validate the theory and could not show exactly how the accident occurred. *Id.*

The court also felt that the plaintiff met its burden in *Mulholland,* 403 Mich. at 417. In that case plaintiff claimed that defendant's milking system caused mastitis in his dairy herd. Plaintiff produced a well-qualified expert who testified that defendant's system was defective and likely caused the disease when it damaged the teat ends, thereby making the cows more susceptible to bacterial infection upon contact. *Mulholland, 432 Mich. at 412.* [*9] This was a logical explanation. Therefore, it was enough evidence to defeat a claim of summary judgment. *Id.*

Plaintiff, in the present case, of fared no direct proof that the claimed manufacturing defect was attributable to Defendant. As to circumstantial proof she offers the following: First, that the package the razor was shipped in was not damaged; therefore, the defect was present when the razor was packaged by Defendant; second, the accident itself. According to Pulley these facts show that the only plausible explanation is that the defect was caused by Defendant. I disagree and, in light of the paucity of evidence submitted by Pulley, find that there is no reasonable basis for inferring that the alleged defect was probably caused by Gillette.

That the accident occurred does not relieve Plaintiff of her burdens, *Skinner 445 Mich. at 163.* Plaintiff's claim concerning the packaging merely states a belief and does not establish a logical sequence of events. In order to establish a logical sequence of events Plaintiff must offer evidence in the form of expert testimony, similar to that offered in *Holloway,* or a theory analogous [*10] to

the plaintiff's theory in *Mulholland.* Here Pulley neither offered an expert nor a theory that she can support with circumstantial evidence. Contrary to plaintiff's belief, neither a cursory inspection of the package prior to opening, nor a pronouncement by the interested Plaintiff that it was undamaged, rises to the level of circumstantial evidence or suggests that any defect in the razor is attributable to Defendant.

It is clear that Plaintiff cannot meet her burden of showing that the manufacturing defect was attributable to Defendant. Disposition of this issue makes it unnecessary to address the "failure to warn" claim. *Skinner v. Square D, 195 Mich. App. 664, 491 N.W.2d 648 (1992)* aff'd *Skinner, 445 Mich. at 175.*

C. *Res Ipsa Loquitur*

The *res ipsa loquitur doctrine* will not assist Pulley's claim. [3] Failure to offer a scintilla of circumstantial evidence that satisfies the *Jones* test is fatal. *Jones, 428 Mich. at 151.* [HN5] Alleging a *res ipsa loquitur* claim only means that the plaintiff is entitled to a permissible inference [*11] of negligence from circumstantial evidence. *Id. at 152.* Contrary to Plaintiff's apparent belief, mere injury does not impute negligence upon anyone, *Locke v. Pachtman,* 1994 WL 513763 (Mich. Aug. 3, 1994). It only presents an opportunity to grasp the *res ipsa loquitur* lifeline. Here Pulley does not meet the *Jones* test.

> 3 Plaintiff did not state a *res ipsa loquitur* claim in her complaint; however, both parties addressed this issue in their briefs concerning this motion. Therefore the Court will address the reasons for its decision that the principle of *res ipsa loquitur* is inapplicable in the present case.

Plaintiff cannot satisfy the first prong since none of her proofs show that this was an accident that usually does not happen without the negligence of another party. While a razor blade cut that requires thirty stitches is a horrible gash, it is not within the highly exceptional group of cases in which the injury is more often than not due to the [*12] negligence of the razor blade manufacturer. In fact, common experience, the foundation upon which the *res ispa loquitur* doctrine rests, suggests the exact opposite; that is, that a gash requiring thirty stitches rarely occurs because a small hand-held razor is defective.

Plaintiff's response also illustrates her inability to meet the second and fourth conditions. The only evidence that was presented on the control of the razor was given by Gillette. According to Defendant several parties controlled the razor, including the store where the razor was purchased, a warehousing company and a distributor. Thus, any one of these entities may have caused the defect of which Plaintiff complains. The facts which establish that Plaintiff cannot meet the second condition also establish that she cannot meet the fourth.

Conclusion

Accordingly Defendant's motion for summary judgment is granted. IT IS SO ORDERED.

John Feikens

United States District Judge

Dated: Oct 13, 1994

# EXHIBIT J

1992 WL 1071358 (Pa.Com.Pl.)
Court of Common Pleas of
Pennsylvania, Philadelphia County

Susan Mattie
v.
Sacred Heart Hospital et al.

No. 4943.
|
October Term, 1984
|
January 29, 1992

**Attorneys and Law Firms**

*Thomas Kline,* Esquire, for Plaintiff.

*James Jordan,* Esquire, for Defendant.

## OPINION

MAIER, J.

This Opinion is in support of this court's Order of April 11, 1991, in which the court denied Plaintiff's Motion for Post-Trial Relief and ordered that final judgement be entered on its July 14, 1989 defense verdict.

## PROCEDURAL HISTORY

This is a medical malpractice action by Plaintiff, Susan Mattie, seeking to recover damages for injuries she sustained as a result of a thyroidectomy procedure performed by Defendants, Dr. Alan Dorian and Dr. Harry Nelson, at Sacred Heart Hospital and Rehabilitation Center on December 28, 1982. The original action ended on July 1, 1988 by an Order granting defendants' Motion for Summary Judgement. The plaintiff appealed to the Superior Court and the case was remanded on June 21, 1989. The case then proceeded to trial before this Court on July 7, 1989. After a four ***532** day trial, the jury returned a defense verdict. Subsequently, plaintiff filed a Motion for Post-Trial Relief praying for a Judgement N.O.V., or in the alternative, a new trial. This Court denied plaintiff's Motion for Post-Trial Relief and that is the subject of this opinion.

## STATEMENT OF FACTS

In 1982, Susan Mattie was a 19 year old woman suffering from Graves Disease. As a result of this disease, she developed an enlarged thyroid gland which required a surgical resection. Plaintiff's internist referred her to defendants Dr. Dorian and his partner, Dr. Nelson who performed the surgery.

The day after surgery, plaintiff developed breathing difficulty. An examination revealed that plaintiff's left vocal cord was totally paralyzed and that her right vocal cord only moved slightly. The parties have generally agreed that the paralysis was due to injury to the recurrent laryngeal nerves during surgery, but have offered only speculation as to the cause.

The plaintiff advanced her action upon the *res ipsa loquitur* doctrine. Specifically, the plaintiff alleged that she had no damage to her vocal cords prior to surgery on December 28, 1982, and that during the surgery her recurrent laryngeal nerves were damaged, a result which does not ordinarily occur in absence of negligence. Defendants, however, contend that surgery proceeded without incident and in accordance with proper medical procedures.

The plaintiff offered into evidence the testimony of Dr. Richard Bassin, a general surgeon, as an expert witness. Dr. Bassin testified that a surgeon has a duty to locate and protect the nerve throughout the whole procedure (N.T. 7/10/89, pp. 56, 60) and that in all of his years of medical experience, he had never been involved with, or heard of, laryngeal nerve injury (N.T. 7/10/89, p. 48). Dr. Bassin testified that in his medical opinion, the injury occurred ***533** during surgery and this constituted medical negligence (N.T. 7/10/89, pp. 71-77, 79).

Defendant, Dr. Dorian testified to the fact that nerve damage is a known complication of a thyroidectomy and can occur in the absence of negligence (N.T. 7/11/89, pp. 32, 35). Dr. Dorian also testified that the proper standard of care was used in identifying and protecting the nerve (N.T. 7/11/89, pp. 48-56, 73) and that he did not know what caused the injury to the plaintiff's vocal cords or laryngeal nerve (N.T. 7/11/89, p. 64). Co-defendant Dr. Nelson testified that he had previously witnessed a case of bilateral cord paralysis following an operation that had no complications (N.T. 7/13/89, p. 12), and that there are risks no matter how careful the surgery proceeds (N.T. 7/13/89, p. 18). Additionally, defendant Dr. Nelson, in testimony similar to the testimony of Dr. Dorian, confirmed that there was no deviation or departure from the standard of due care in operating on the plaintiff (N.T. 7/13/89, p. 44).

The defense called as their expert, Dr. Herbert Kean, an otolaryngology specialist who also concurred with Dr. Dorian's contention that this type of nerve injury can occur even when all proper care has been exercised (N.T. 7/13/89, pp. 118-120).

After hearing all testimony, the jury returned a defense verdict. Plaintiff filed for Post-Trial Relief alleging that the trial court committed two basic evidentiary errors, both related to the admission of testimony at trial. This court disagrees and denies plaintiff's request for Post-Trial Relief.

## DISCUSSION

### *A. This Court Properly Allowed The Defendants To Testify As To Their Prior Experience Regarding Laryngeal Nerve Injury*

The plaintiff's first objection is that the trial court erred in permitting the defendant physicians to testify, over the ***534** plaintiff's objection, that both had in the past, successfully performed hundreds of thyroid operations without causing bilateral laryngeal nerve damage to a patient.

  

It is conceded by the defendants that the law in Pennsylvania is that a defendant's reputation for acting with care is generally not admissible to rebut a claim of negligence. *Mertz v. Detweiler,* 8 W. & S. 376 (Pa. 1845). But, as the defendants correctly point out in their reply brief, where the evidence is offered for another purpose, specifically where the evidence has probative force to, and is introduced to, rebut an inference sought to be drawn by the opinion testimony of an opposing expert witness, the evidence is properly admissible. *Packel, Pennsylvania Evidence,* §405.3 (1987), *Baumeister v. Baugh and Sons Co.,* 142 Pa.Super. 346, 16 A.2d 424, 427 (1940).

Dr. Nelson's testimony regarding his performance of prior thyroid operations was introduced for the purpose of establishing that the injury which occurred in the instant case can occur in the absence of negligence (N.T. 7/13/89, p. 12). Dr. Dorian's testimony regarding his experience with operations of the thyroid gland was similarly introduced (N.T. 7/11/89 p. 32). Therefore, because the defendants' testimony as to their experience was not solicited to establish their reputation for care but for the limited purpose of rebutting the inferences sought to be drawn out by the opponent's expert witness, specifically that such injury does not occur in the absence of negligence, plaintiff's contention as to the inadmissibility of this evidence is without merit.

Independent of this analysis, however, Dr. Dorian's testimony was properly placed before the jury in his recital of his informed consent discussion with the plaintiff and her parents, during which he advised them of his prior experience and the fact that no patient of his had suffered this complication (N.T. 7/11/89, p. 32). In addition, since there was no objection or limited instruction request as to the admission of this testimony when elicited in this informed consent recital context, the repetition of this testimony was ***535** harmless error. *Kubit v. Russ,* 287 Pa.Super. 28, 429 A.2d 703 (1981); *Robinson v. City of Philadelphia,* 329 Pa.Super. 139, 478 A.2d 1 (1984).

*B. This Court Properly Allowed Defendant's Medical Expert To Offer Opinion Testimony With Respect To Recurrent Laryngeal Nerve Injury*

The plaintiff's second objection is that the court erred in allowing defendants' medical expert, Dr. Kean, to offer opinion testimony on the performance, standard of care and complications involved with thyroid surgery. Plaintiff asserts that Dr. Kean admitted that he was not qualified to express an opinion, he is not a thyroid surgeon, and that he is not an expert in that field.

The plaintiff has mischaracterized the nature and purpose of Dr. Kean's testimony. Dr. Kean was qualified as a specialist in disorders of ear, nose and throat, including the injuries to the vocal cords and recurrent laryngeal nerve injury, with particular experience in treating patients with vocal cord problems occurring subsequent to thyroid surgery. Dr. Kean did *not* state that he was not qualified to express an opinion

and his testimony was not offered as an opinion of a thyroid surgeon. Instead, he stated he was, and was offered as, an expert in treating patients with problems occurring after thyroid surgery (N.T. 7/13/89, pp. 107, 108), who is knowledgeable about the standards followed by a surgeon in protecting the laryngeal nerves (N.T. 7/13/89, p. 109) and the causes of recurrent laryngeal nerve injury (N.T. 7/13/89 pp. 120-123).

Under Pennsylvania law, a witness is qualified to express an opinion as an expert where the witness is shown to have sufficient skill, knowledge or expertise in that field. *Palmer v. Lapp,* 392 Pa.Super. 21, 572 A.2d 12 (1990). In addition, a witness may be qualified to testify even though he has no particular knowledge of the subject matter, where the scope of the witness's experience and education embraces the ***536** subject in question in a logical or fundamental sense. *Dambacher by Dambacher v. Mallis,* 336 Pa.Super. 22, 43, 485 A.2d 408, 418 (1984); *Whistler Sportswear, Inc. v. Rullo,* 289 Pa.Super. 230, 433 A.2d 40 (1981).

In the instant case, Dr. Kean's ear, nose and throat practice involves the examination and care of vocal cords, recurrent laryngeal nerves and injury to the nerves as a result of thyroid surgery. Plaintiff attempts to analogize this set of facts to a case in which an eye doctor was precluded from testifying about heart disease and a case where a radiologist was precluded from testifying about diabetes. The instant case is not analogous to these rulings. Dr. Kean is a specialist in injuries to the vocal cords and was testifying as an expert in a case involving injuries to the vocal cords.

Assuming arguendo, that he is not qualified to testify about thyroid surgery because he is not a surgeon, it is clear that he is qualified to testify as an expert about injury to the vocal cords during surgery, according to the *Dambacher* standard enumerated above. Dr. Kean certainly has experience and education with respect to vocal cords and knowledge and expertise in laryngeal nerve injury. The instant case is analogous to a case where a neurosurgeon was permitted to testify about auditory and ophthalmological problems. Although he was a brain specialist, the court determined that those functions are closely related to the surgeon's field of expertise, and thus, expert testimony was properly elicited from him. *Christy v. Darr,* 78 Pa.Commw. 354, 467 A.2d 1362 (1983). Therefore, Dr. Kean was qualified to testify about the plaintiff's injury and the admission of Dr. Kean's testimony was proper.

## CONCLUSION

For the reasons set forth above, the jury's proper verdict for defendants is upheld and plaintiff's Motion for Post-Trial Relief is denied.

### All Citations

1992 WL 1071358, 23 Phila.Co.Rptr. 531

End of Document

# EXHIBIT K

2006 WL 728068
Only the Westlaw citation
is currently available.

SEE TX R RAP RULE 47.2
FOR DESIGNATION AND
SIGNING OF OPINIONS.

**MEMORANDUM OPINION**
Court of Appeals of Texas,
Eastland.

Kelly KUYKENDALL and Husband,
Terry Kuykendall, Appellants
v.
Michael J. DRAGUN, M.D. and
West Texas Urology, Appellees.

No. 11-05-00230-CV.
|
March 23, 2006.

**Synopsis**

**Background:** Patient filed medical malpractice action against surgeon who was brought in during surgery to address complications from perforation of patient's bladder. The 142nd District Court, Midland County, granted surgeon's motion to dismiss. Patient appealed.

**Holdings:** The Court of Appeals, Rick Strange, J., held that

[1] expert report submitted by patient did not satisfy statutory requirements, and

[2] trial court did not abuse its discretion when it denied patient's request for a 30-day grace period to amend report.

Affirmed.

West Headnotes (2)

**[1] Health**
Affidavits of Merit or Meritorious Defense;Expert Affidavits
198H Health
198HV Malpractice, Negligence, or Breach of Duty
198HV(G) Actions and Proceedings
198Hk804 Affidavits of Merit or Meritorious Defense;Expert Affidavits

Expert report submitted by patient in her medical malpractice claim against surgeon was not a good-faith effort to provide a fair summary of expert's opinions, as required by statute, as to surgeon who was brought in during surgery to address complications from perforation of patient's bladder; report failed to provide specific information concerning surgeon's conduct, report assumed that both surgeons involved in the surgery were equally responsible for patient's injury, and report relied upon assumptions to determine "most likely" cause of patient's injuries. Vernon's Ann.Texas Civ.St. art. 4590i § 13.01 (repealed).

  

1 Cases that cite this headnote

**[2] Health**

Affidavits of Merit or Meritorious Defense;Expert Affidavits

198H Health
198HV Malpractice, Negligence, or Breach of Duty
198HV(G) Actions and Proceedings
198Hk804 Affidavits of Merit or Meritorious Defense;Expert Affidavits

Trial court did not abuse its discretion when it denied patient's request for a 30-day grace period to amend medical expert's report, after trial court found that report did not satisfy statutory requirements, in patient's medical malpractice claim against surgeon who was brought in during surgery to address complications from perforation of patient's bladder; trial court could have reasonably concluded that patient had the ability to distinguish between the actions of the two surgeons involved in the surgery and determine what surgical equipment and procedures were utilized and that patient's failure to do so precluded a thirty-day grace period. Vernon's Ann.Texas Civ.St. art. 4590i § 13.01(g) (repealed).

1 Cases that cite this headnote

On Appeal from the 142nd District Court, Midland County, Texas, Trial Court Cause No. CV45114.

**Attorneys and Law Firms**

Rick Dunbar, for Appellants.

Jack Tidwell, for Appellees.

Panel consists of WRIGHT, C.J., and McCALL, J., and STRANGE, J.

## MEMORANDUM OPINION

RICK STRANGE, Justice.

***1** This is a medical malpractice action. Michael J. Dragun, M.D. and West Texas Urology filed a motion to dismiss contending that Kelly and Terry Kuykendall's expert report did not satisfy the requirements of TEX.REV.CIV. STAT. art. 4590i, § 13.01 (2001).[1] The trial court granted appellees' motion to dismiss and denied appellants' request for an extension of time to file an amended report. We find no error and affirm.

1 Although applicable to this case, Article 4590i was repealed effective September 1, 2003; and the subject matter is now governed by TEX. CIV. PRAC. & REM.CODE ANN. § 74.351 (Vernon Supp.2005).

### *Facts*

Kelly Kuykendall underwent a bilateral salphingo-oophorectomy and a laparoscopic-assisted vaginal hysterectomy

  

on June 24, 2002. The surgery was performed by Dr. Brady Locke. Kelly's bladder was perforated during the surgery. Dr. Dragun was contacted and was asked to repair the injury. He performed a laparotomy and was assisted in the procedure by Dr. Locke.

The original surgery was scheduled for two hours. Because of the bladder complication, the surgery lasted six hours. Appellants allege that Kelly's peripheral nerves were damaged during the extended surgery.

Appellants filed a medical malpractice action against Dr. Dragun and other health care providers on May 29, 2003. They timely filed the expert report and curriculum vitae of Dr. Mearl A. Naponic. Appellees filed a motion to dismiss, contending the expert report did not satisfy the requirements of Article 4590i, section 13.01. Appellants responded that Dr. Naponic's expert report was sufficient and, alternatively, requested an Article 4590i, section 13.01(g) thirty-day extension. The trial court conducted a hearing and granted appellees' motion to dismiss and denied appellants' request for an extension.

*Issues*

In two issues, appellants contend that their expert report satisfies the requirements of Article 4590i, section 13.01 or, alternatively, that the trial court abused its discretion by denying their request for an Article 4590i, section 13.01(g) thirty-day grace period to amend their report.

*Standard of Review*

A trial court's decision to dismiss a lawsuit because of an inadequate expert report is reviewed under an abuse of discretion standard. *Am. Transitional Care Ctrs. of Tex., Inc. v. Palacios,* 46 S.W.3d 873, 878 (Tex.2001). A trial court's decision to grant or deny an Article 4590i, section 13.01(g) grace period is also reviewed under an abuse of discretion standard. *Walker v. Gutierrez,* 111 S.W.3d 56, 62 (Tex.2003).

A trial court abuses its discretion if it acts in an arbitrary or unreasonable manner without reference to any guiding rules or principles. *Downer v. Aquamarine Operators, Inc.,* 701 S.W.2d 238, 241-42 (Tex.1985). A reviewing court is not allowed to substitute its judgment for that of the trial court when reviewing a discretionary decision. *Flores v. Fourth Court of Appeals,* 777 S.W.2d 38, 41-42 (Tex.1989). The mere fact that a trial court may decide a matter within its discretionary authority in a different manner than an appellate court in a similar circumstance does not demonstrate that an abuse of discretion has occurred. *Downer,* 701 S.W.2d at 241-42.

*Does Dr. Naponic's Report Satisfy Article 4590i?*

*2 **[1]** In *Palacios,* 46 S.W.3d at 878-79, the supreme court outlined the criteria for evaluating the efficiency of expert reports. Specifically, the court wrote:

  

> [T]he expert report must represent only a good-faith effort to provide a fair summary of the expert's opinions. A report need not marshal all the plaintiff's proof, but it must include the expert's opinion on each of the elements identified in the statute. In setting out the expert's opinions on each of those elements, the report must provide enough information to fulfill two purposes if it is to constitute a good-faith effort. First, the report must inform the defendant of the specific conduct the plaintiff has called into question. Second, and equally important, the report must provide a basis for the trial court to conclude that the claims have merit.
>
> A report that merely states the expert's conclusions about the standard of care, breach, and causation does not fulfill these two purposes. Nor can a report meet these purposes and thus constitute a good-faith effort if it omits any of the statutory requirements. However, to avoid dismissal, a plaintiff need not present evidence in the report as if it were actually litigating the merits. The report can be informal in that the information in the report does not have to meet the same requirements as the evidence offered in a summary-judgment proceeding or at trial. (citations omitted)

Courts have identified additional considerations when multiple defendants are sued. In that instance, the expert report must provide an explanation of how each defendant specifically breached the applicable standard of care and how that breach caused or contributed to the cause of injury. *Taylor v. Christus Spohn Health Sys. Corp.*, 169 S.W.3d 241, 244 (Tex.App.-Corpus Christi 2004, no pet.).

That portion of Dr. Naponic's expert report which addressed Dr. Dragun's actions contained the following language:

> On June 24, 2002, Kelly Kuykendall underwent bilateral salphingo-oophorectomy, as well as a laparoscopic assisted vaginal hysterectomy. Theses [sic] surgical treatments were performed in an effort to relieve pre-operative symptoms of pelvic pain, dysmenorrhea and menorrhagia and failed medical management of same. The initial procedure scheduled for two hours was performed by Dr. Brady Locke and was complicated by an intra-operative injury to the bladder. The perforation of the bladder necessitated surgical repair; and, thus this two hour surgery evolved into a six hour surgery, involving a laparotomy to repair an incision into the bladder of approximately eight to nine centimeters. This second surgery was performed by Dr. Michael Dragun and assisted by Dr. Brady Locke.
>
> The standard of care for such procedures as described above, necessarily require[s] that the peripheral nerves in and adjacent to the operative site be identified and protected. This is particularly true when a self-retaining retractor is used and the length of the surgery is prolonged. Complications, including nerve injuries, from self-retaining retractors are well-known and well-described in the relevant

> literature. Failing to properly pad the self-retaining retractor, failure to adequately position the patient and/or leaning on the patient during this prolonged surgery are the most likely cause of the intra-operative injuries and complications suffered by Kelly Kuykendall and are below the accepted standard of care for these procedures. As both Dr. Locke and Dr. Dragun performed the bladder repair, they shared the responsibility to protect Kelly Kuykendall against this injury.

***3** A fair summary is something less than a full statement of the applicable standard of care and how it was breached. A fair summary must set out what care was expected but not given. *Palacios,* 46 S.W.3d at 880 ("[w]hether a defendant breached his or her duty to a patient cannot be determined absent specific information about what the defendant should have done differently"). An expert report must show causation beyond mere conjecture. *Bowie Mem'l Hosp. v. Wright,* 79 S.W.3d 48, 52 (Tex.2002). Knowing what specific conduct the plaintiff's expert has called into question is critical to both the defendant's ability to prepare for trial and the trial court's ability to evaluate the viability of the plaintiff's claims. *Palacios,* 46 S.W.3d at 876-77. Dr. Naponic's report does not provide this level of information because his analysis is premised on several assumptions and because he fails to distinguish between the actions of Dr. Locke and Dr. Dragun.

Dr. Naponic's analysis is similar to a res ipsa approach. Because Kelly suffered from peripheral nerve damage and because the relevant literature documents a connection between that injury and the failure to properly pad self-retaining retractors, improperly positioning the patient, or leaning on the patient, Dr. Naponic assumes that these are the "most likely" causes of her injury. He assumes further that Dr. Locke and Dr. Dragun are collectively responsible for one or more of these actions. [2]

2 In *Palacios,* the supreme court noted that, as a general rule, *res ipsa loquitur* does not apply in medical malpractice cases. 46 S.W.3d at 880. Consequently, an expert report must do more than simply assume that a health care provider is responsible for any surgical complication.

There are several problems with this approach. First, Dr. Naponic's report does not document that a self-retaining retractor was even used or, if so, by whom. This is not a question of mere semantics. Dr. Dragun cannot be held responsible for any actions taken before he arrived in the operating room, nor can he be held responsible for improperly using equipment that was never utilized. Knowing what Dr. Naponic alleges Dr. Locke did during the initial portion of the procedure and what Dr. Naponic alleges happened during Dr. Dragun's portion of the procedure are vital.

Second, even assuming Dr. Dragun used a self-retaining retractor, Dr. Naponic did not document how it was padded or how it should have been padded. Third, the report does not document how Kelly was positioned at any point in time during her surgical procedure, nor how she should have been positioned during Dr. Dragun's procedure. Finally, the report provides no support for his hypothesis that Dr. Dragun leaned on Kelly beyond his contention that

this is frequently the cause of her type of injury.

The supreme court's holding in *Palacios,* 46 S.W.3d at 873, that a trial court's decision to grant a motion to dismiss is subject to an abuse of discretion review, mandates that we provide trial courts with some deference when determining what constitutes a good faith effort to comply with the statute in a particular case. Because Dr. Naponic's report failed to provide specific information concerning Dr. Dragun's conduct, because he assumed the two doctors were equally responsible for Kelly's injury, and because Dr. Naponic relied upon assumptions to determine the "most likely" cause of her injury, we hold the trial court did not abuse its discretion when it granted appellees' motion to dismiss. Appellants' first issue is overruled.

*Were Appellants Entitled To A Thirty-Day Extension To Amend Their Report?*

***4 [2]** Article 4590i, section 13.01(d) required claimants to furnish an expert report within 180 days after the claim was filed. Article 4590i, section 13.01(g) gave trial courts the discretion to provide a thirty-day grace period to file an amended report if the failure to timely file an adequate report "was not intentional or the result of conscious indifference but was the result of an accident or mistake."

In their response to appellees' motion to dismiss, appellants included an alternative request for a thirty-day extension based upon their belief that Dr. Naponic's report was adequate and, if not, contended that their failure to provide an adequate report was due to accident or mistake and not an intentional act or conscious indifference. Appellants' request was supported by the testimony of their trial counsel who stated that he contacted Dr. Naponic based upon the referral of a general surgeon, that he provided Dr. Naponic with the relevant records and caselaw, that they discussed this case, that Dr. Naponic indicated that it would be difficult to distinguish from the medical records which defendant caused the intraoperative injuries absent an admission, but that Dr. Naponic informed him that all the health care providers shared a duty to protect Kelly. Counsel testified that he relied upon Dr. Naponic, who was a board-certified obstetrician and gynecologist, to provide him with a sufficient report and that he believed Dr. Naponic had done so.

The Texas Supreme Court faced a similar situation in *Walker,* 111 S.W.3d at 56. There, as here, claimant's counsel mistakenly believed that his expert's report was sufficient. The supreme court comprehensively reviewed intermediate court decisions on Article 4590i, section 13.01(g) extensions, finding that some courts were erroneously holding that any mistake of law was sufficient to support an extension while others were impermissibly applying a standard that precluded an extension because of a mistake of law. *Id.* at 63-64. According to the supreme court, some- but not all-mistakes of law may negate a finding of intentional conduct or conscious indifference and, therefore, support an

  

extension. The distinction turns on the knowledge and acts of the claimant. *Id.* at 64.

The supreme court concluded that counsel's belief that his expert's report was sufficient, despite clear statutory requirement to the contrary, "does not establish a 'sufficient excuse' necessary to support a finding that a party made a mistake of law." *Id.* at 64-65. This follows because a medical malpractice claimant is charged with knowledge of Article 4590i, section 13.01 and its requirements. *Id.* Appellants distinguish *Walker* by alleging it involved a report which was absent the relevant standard of care and how the defendants breached that standard. Appellants contend that, if their report is inadequate, it is not because of the absence of a critical element but simply insufficient information.

***5** The trial court is best positioned to assess what appellants knew and to evaluate their actions. The extent and quality of the information available to a medical-malpractice claimant will vary from case to case. That information directly impacts the report a good faith effort will produce. We have found that the trial court did not abuse its discretion when it held Dr. Naponic's report was insufficient because Dr. Naponic failed to distinguish between the actions of the two doctors and because his analysis relies heavily on assumption. During oral argument, appellants' counsel pointed out that physicians are unlikely to admit to errors in their medical records and, therefore, that one cannot expect doctors to affirmatively state that they leaned on their patient during surgery. Even if we accept this as true, the medical records would contain information on the surgical equipment utilized, the manner in which the patient was positioned, and the surgery conducted. Because two different doctors operated on Kelly, their respective records would provide information unique to each doctor and their procedures. The trial court could have reasonably concluded that in this case appellants had the ability to distinguish between the actions of the two doctors and determine what surgical equipment and procedures were utilized and that their failure to do so precluded a thirty-day grace period.

The cases decided since *Walker* indicate that the trial court's decision to grant or deny a thirty-day grace period when counsel argues that his mistaken belief that a report was sufficient constitutes a mistake of law, are afforded great deference due to their individual factual patterns. *Compare In re Zimmerman,* 148 S.W.3d 214, 217 (Tex.App.-Texarkana 2004, orig. pro-ceeding) (affirming the trial court's decision to grant a thirty-day grace period based upon mistake of law) *with Sandles v. Howerton,* 163 S.W.3d 829, 838 (Tex.App.-Dallas 2005, no pet.)(affirming the trial court's decision to not grant a thirty-day grace period based upon a mistake of law).

We cannot say that the trial court abused its discretion when it denied appellants' request for a thirty-day grace period. Appellants' second issue is overruled.

*Conclusion*

The trial court did not abuse its discretion when it granted appellees' motion to dismiss and denied appellants' request for a thirty-day grace period. The trial court's judgment is affirmed.

**All Citations**

Not Reported in S.W.3d, 2006 WL 728068

End of Document

# EXHIBIT L

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Court of Appeal, Second
District, Division 3, California.

Susan HAHN et al.,
Plaintiffs and Appellants,
v.
U.S.C. UNIVERSITY HOSPITAL et
al., Defendants and Respondents.

No. B170719.
|
(Los Angeles County
Super. Ct. No. BC268059).
|
May 25, 2005.

APPEAL from a judgment of the Superior Court of Los Angeles County, Victor H. Person, Judge. Affirmed in part and reversed in part.

**Attorneys and Law Firms**

Agajanian, McFall, Weiss, Tetreault & Crist, Scott B. McFall, Graciela L. Freixes, and Donald Ornelas, Jr., for USC University Hospital and David J. Hart, Defendants and Respondents.

Bonne, Bridges, Mueller, O'Keefe & Nichols, David J. O'Keefe, Mark B. Connely, and Vangi M. Johnson for John Peter Gruen, University of Southern California Neurosurgeons, and University of Southern California Head and Neck, for Defendants and Respondents.

Gary Rand & Suzanne E. Rand-Lewis and Suzanne E. Rand-Lewis, for Plaintiffs and Appellants.

ALDRICH, J.

## INTRODUCTION

***1** After undergoing cervical disc surgery and a subsequent thyroplasty, plaintiff and appellant Susan Hahn (Ms. Hahn) brought this medical malpractice lawsuit. She appeals from a summary judgment entered against her. The issues concern the sufficiency of the declarations submitted in favor of and in opposition to a number of summary judgment motions. We affirm in part and reverse in part.

## FACTUAL AND PROCEDURAL BACKGROUND

1. *Preliminary facts.*

In October 2000, Ms. Hahn suffered a workplace back injury.

On November 4, 2000, Ms. Hahn underwent a MRI of her cervical spine, due to complaints of pain in her spine radiating into her right arm, and additionally due to

complaints of numbness, tingling, decreased range of motion, and decreased strength in her right arm. A MRI revealed mild to moderately severe degenerative changes, a large disc extrusion or disc herniation, and there were cervical room compression concerns.

No one informed Ms. Hahn that the MRI also showed an anomaly in her throat (fullness in the region of the base of the tongue centrally and to the right of the midline).

Ms. Hahn underwent a brief course of physical therapy and received epidural injections.

Upon recommendation, Ms. Hahn was referred to defendant and respondent Dr. John Peter Gruen for a surgical consultation.

On February 22, 2001, Dr. Gruen recommended Ms. Hahn undergo an anterior cervical discectomy at the C6-7 level. Ms. Hahn was not informed that the anomaly in her throat might cause a problem during surgery because of the route to be taken during the recommended procedure. She was not informed that there was an alternate route that could be used. Even though the anomaly was found, Ms. Hahn was not referred to an ear, nose, and throat specialist for further evaluation or testing.

On March 5, 2001, Ms. Hahn underwent an anterior cervical discectomy with placement of a bone spacer and synthes plate and screw system. The surgery was performed at defendant and respondent University of Southern California Hospital (USC Hospital) by Dr. Gruen, assisted by defendant and respondent David J. Hart, M.D. At the time, Dr. Hart was a fourth-year neurosurgical resident at USC Hospital.

Prior to surgery, Ms. Hahn signed one page of a multi-page hospital consent form; however, she was not given an opportunity to read it.

While in the hospital after surgery, Ms. Hahn complained that she could not talk, swallow, or cough. She was unable to drink or eat without choking. Her vocal cord was paralyzed. Dr. Gruen did not see Ms. Hahn while she was in the hospital. Ms. Hahn was discharged the day after the surgery. At that time, she was exhibiting mild hoarseness.

Thereafter, Ms. Hahn's father (Dr. Philip Ryan) contacted Dr. Gruen. Upon Dr. Ryan's demand, Dr. Gruen referred Ms. Hahn to Uttam Sinha, M.D. at USC Hospital on April 8, 2001. At that time, Dr. Gruen talked to Ms. Hahn and stated he was " 'sorry' and that he had been 'in denial' as to the seriousness of [her] condition." Dr. Sinha was associated with defendant and respondent University of Southern California Head and Neck (USC Head & Neck).

***2** Dr. Sinha diagnosed right vocal cord paralysis and recommended a thyroplasty to improve the vocal cord function. Dr. Sinha performed this surgery on May 15, 2001, at the USC Hospital. Thereafter, Dr. Sinha recommended Ms. Hahn stop smoking and

undergo voice therapy. Ms. Hahn did not follow these recommendations.

2. *Procedure.*

a. *The complaint.*

On February 13, 2002, Ms. Hahn filed this medical malpractice lawsuit against Dr. Gruen, Dr. Hart, the USC Hospital, the University of Southern California University Neurosurgeons, Inc. (USC Neurosurgeons) and USC Head & Neck, collectively defendants.[1] Ms. Hahn alleged she received negligent medical care and treatment from defendants who were "engaged in acts or omissions that fell below the standard of skill and competence and commonly exercised by health care providers in the community, which negligence was the legal cause of [her] resulting permanent injuries ." According to the allegations of the complaint, as a result of professional negligence by the various physicians, Ms. Hahn sustained a laryngeal nerve injury and aspiration, beginning with the first surgery. Further, she continued to suffer from ongoing aspiration problems necessitating ongoing medical treatment and at times hospitalization to remove the aspirated material from her lungs. She suffered permanent damage to her vocal cord and could barely speak above a whisper.[2]

1 The additionally named defendants, including Dr. Sinha, are not parties to this appeal.

2 Ms. Hahn used a form complaint, with an attachment. The allegations of the complaint were based solely upon negligence, the intentional tort box was not checked on the form, and there were no allegations of battery or concealment.

A cause of action for loss of consortium was filed on behalf of Ms. Hahn's husband, Thomas Hahn. He may recover only if Ms. Hahn has a viable cause of action. (*Blain v. Doctor's Co.* (1990) 222 Cal.App.3d 1048, 1067; *Meighan v. Shore* (1995) 34 Cal.App.4th 1025, 1034.) Mr. Hahn appears as an appellant in this appeal. For ease of reference, and unless otherwise noted, we refer only to Ms. Hahn.

b. *The attempts to mediate and facts relating to notice of Dr. Gruen's deposition.*

By July 8, 2002, the parties had agreed to mediate the dispute. In September 2002, the trial court appointed a mediator. The mediation set for September 2002, was continued to November 2002. The mediation was unsuccessful.

There were some discovery disputes and Dr. Gruen's deposition was set on two dates, one in January and one in February 2003. The parties again tried to resolve the case through mediation, and Dr. Gruen's deposition was rescheduled to dates in February and March 2003. In February 2003, the parties reported that mediation had been unsuccessful, but they were willing to try again; the date for mediation was extended to June 30, 2003.

In March 2003, a number of discovery disputes were brought to the trial court's attention.

A May 28, 2003, mediation was unsuccessful. On May 28, 2003, the first of the summary judgment motions discussed below was served on Ms. Hahn. It and the other such motions were set to be heard on August 15, 2003.

On June 20, 2003, Dr. Gruen's counsel inquired as to whether Dr. Gruen's deposition would be taken by Ms. Hahn's counsel.

On July 28, 2003, Dr. Gruen was designated as an expert on the standard of care. Months earlier, Dr. Gruen had refused to answer interrogatories on the ground that the interrogatories called for him to render expert opinions.

On July 31, 2003, Ms. Hahn noticed Dr. Gruen's deposition for August 15, 2003, the same date as the hearing on the summary judgment motions.

c. *The motions for summary judgment.*

(1) *USC Head & Neck's summary judgment motion.*

***3** On May 28, 2003, and as amended on May 30, 2003, USC Head & Neck filed a motion for summary judgment. The declaration of Mark Wax, M .D. was attached. USC Head & Neck argued the treatment given by Dr. Sinha had met the standard of care, the thyroplasty was the proper treatment, the thyroplasty was properly performed, records revealed that Ms. Hahn had been informed of the risks and benefits of the procedure, Ms. Hahn signed a consent form for the procedure, and Ms. Hahn's injuries were not the result of Dr. Sinha's treatment. Dr. Wax declared, in part, that the fact Ms. Hahn's voice had improved after the thyroplasty indicated the surgery had been successful.

On August 1, 2003, Ms. Hahn filed an opposition to USC Head & Neck's summary judgment motion, attaching her declaration as well as that of her father, Dr. Ryan.

(2) *Dr. Gruen and USC Neurosurgeons' motion for summary judgment.*

(a) *The moving papers and supporting declarations.*

On May 28, 2003, Dr. Gruen and USC Neurosurgeons filed a joint motion for summary judgment, attaching the declaration of Duncan McBride, M.D. Dr. Gruen and USC Neurosurgeons asserted, based upon Dr. McBride's declaration, that there were no facts indicating Dr. Gruen acted negligently. Dr. McBride declared that the recurrent laryngeal nerve injury occurs in anterior cervical discectomies without any negligence and Ms. Hahn could not establish, to a reasonable medical probability, that the discectomy or the actions of Drs. Gruen and Hart caused her injuries.

(b) *Ms. Hahn's opposition and supporting declarations.*

On August 1, 2003, Ms. Hahn filed an opposition to the summary judgment motion of Dr. Gruen and USC Neurosurgeons. Ms. Hahn attached her own declaration and that of Lloyd Dayes, M.D.

Ms. Hahn declared that prior to the first surgery, no one had informed her that there was an alternate procedure or route that could have been used to avoid putting pressure on the anomaly in her throat.

She further declared the following. Dr. Gruen never used the term " 'risks and complications,' " she was never given a two-page consent form, and this document was never explained to her. After the first surgery, she did not receive prompt post-operative care even though she made many numerous complaints, including that she could not swallow or breathe. No one diagnosed her problems resulting from the first surgery. She did not receive prompt post-operative care while she was hospitalized to assist her in recovering from the paralysis. Thereafter, when Dr. Gruen saw her in his office, he "apologized and admitted he had been 'in denial' about [her] paralysis."

In his declaration, Dr. Dayes, a surgeon that had performed more than 1,000 cervical procedures in 10 years, declared the following. He had reviewed the medical records and the discovery. His opinions were based upon reasonable medical probabilities under the facts and circumstances as revealed. Even had Ms. Hahn been informed that the discectomy could result in nerve damage, she would not have expected that this surgery might result in paralysis to her larynx. Because the MRI showed Ms. Hahn had " 'fullness in the region of the base of the tongue centrally and to the right of the midline,' " direct visualization was required. Both Dr. Hart and Dr. Gruen were responsible for the visualization. Although Dr. Gruen noted he had reviewed the MRI, his notes neglected to report the positive finding of the anomaly in Ms. Hahn's throat. Prior to the discectomy, Ms. Hahn was not referred to a specialist and she was not informed that the right-sided anomaly could create additional pressure on the laryngeal nerve during the discectomy. Dr. Gruen did not inform Ms. Hahn there was an alternate route for the surgery. It was below the standard of care to fail to prescribe a pre-operative laryngoscopy. The failure of Dr. Hart and Dr. Gruen to diagnose and consider the right-sided anomaly was below the standard of care. The anomaly was known before surgery, was noted twice by the radiologist, and was referred to by Ms. Hahn's neurologist. Dr. Gruen did not see Ms. Hahn before the surgery.

***4** Dr. Dayes further declared that Dr. Hart and USC Hospital did not meet the standard of care as Dr. Hart did not inform Ms. Hahn of the anomaly and he did not diagnose nor treat it. The laryngeal nerve was either severed or avulsed during the surgery. The nerve damage is consistent with the presence of an anomaly. Drs. Gruen and Hart should have reconsidered the site of the operation, or should have been specifically attendant to it during surgery to avoid placing pressure on the laryngeal nerve so as to avoid injury to it.

Dr. Dayes additionally declared the following. Dr. Hart was responsible for the retraction, and given the existence of the anomaly, he did not meet the standard of care in this area. Additionally, Dr. Hart and USC Hospital were responsible for Ms. Hahn's postoperative course. The postoperative care did not meet the standard of care because Dr. Hart's notes were incomplete and he failed to ask Ms. Hahn about her complaints of coughing, choking,

  

aspirating, and inability to speak or swallow. Dr. Hahn failed to diagnose, disclose, or treat Ms. Hahn's paralysis and she was discharged without the same being disclosed to her. While in the hospital, Ms. Hahn should have been referred to another specialist so her aspiration could have been diagnosed. This was essential, as the aspiration caused pulmonary complications that could have been avoided. Had the nerve injury been diagnosed while Ms. Hahn was in the hospital, surgery to reconnect the nerve could have been considered. Ms. Hahn's injuries after surgery were hoarseness, paralysis and aspiration. The records showed Ms. Hahn was hoarse; this was a sign that she was not stable, as Dr. Hart professed.

(c) *Ms. Hahn's continuance request.*

Ms. Hahn requested a continuance of the motions set for August 15, 2003, so Dr. Gruen's deposition could be taken. [3]

3 The continuance request was made in conjunction with Ms. Hahn's opposition to the motion filed by Dr. Gruen and USC Neurosurgeons. It is clear the parties and the trial court understood that the motion was intended to apply to all summary judgment motions.

(3) *The summary judgment motions of USC Hospital and Dr. Hart.*

On June 3, 2003, USC Hospital filed a motion for summary judgment, attaching the declaration of Ronald F. Young, M.D.

On June 3, 2003, Dr. Hart filed a motion for summary judgment. Dr. Hart's declaration and the declaration of Dr. Young were attached. USC Hospital and Dr. Hart argued Dr. Hart's professional services met the standard of care and nothing he did caused Ms. Hahn's injuries.

In his declaration, Dr. Hart declared it was not his responsibility to select the surgical procedure and his participation in Ms. Hahn's care was under the supervision of Dr. Gruen. Dr. Hart admitted he did not specifically remember the surgery, but he was not aware of any information or facts suggesting that custom and practice were not followed. Dr. Hart further admitted he was to assist Dr. Gruen in visualization, was responsible for suction and might have held the retractors.

On August 4, 2003, Ms. Hahn filed an opposition to the motions brought by Dr. Hart and USC Hospital, relying upon the declarations previously submitted by herself, Dr. Dayes, and Dr. Ryan.

d. *The ruling.*

***5** Trial was set for September 15, 2003.

On August 15, 2003, the trial court heard argument on all summary judgment motions.

The trial court first denied Ms. Hahn's motion to continue the hearing.

Previously, all parties had objected to the opposing parties' declarations. The trial court ruled on the objections, granting most objections posed by defendants and overruling most made by Ms. Hahn. The trial court then granted the motions.

  

The trial court rendered a ruling containing very detailed findings of fact.

With regard to the first surgery and Dr. Gruen, USC Neurosurgeons, Dr. Hart, and USC Hospital, the trial court found the following facts were without dispute: (1) Ms. Hahn was a candidate for an anterior cervical discectomy; (2) no complications were noted during the first surgery; (3) laryngeal nerve injury can occur during such surgery, even in the absence of negligence; (4) the occurrence of the injury to Ms. Hahn after the first surgery did not indicate a breach in the standard of care; (5) to a reasonable degree of medical probability, Ms. Hahn's injury was not the result of negligence; (6) no act of Dr. Hart was performed negligently; (7) Dr. Hart complied with the standard of care applicable to a resident; and (8) no act of any employee of USC Hospital caused nor contributed to Ms. Hahn's injuries.

With regard to the first surgery and its aftermath, the trial court held that the declaration of Dr. Dayes was insufficient to raise a triable issue of fact.

With regard to the second surgery and USC Head & Neck (and Dr. Sinha who is not a party on appeal), the trial court found the following facts were undisputed: the thyroplasty was indicated, timely, and did not cause Ms. Hahn's injuries. The trial court further found that the medical evidence contained in Dr. Ryan's declaration was insufficient to raise a triable issue of fact.

Thereafter, judgments were filed against Ms. Hahn and in favor of defendants.

e. *The request for costs.*

After judgments were entered, defendants submitted memorandums of costs. Ms. Hahn made motions to tax. The trial court struck a few items, but granted most of the costs items requested.

Ms. Hahn appealed.

## DISCUSSION

1. *Standard of review and the rules guiding medical malpractice cases.*

In moving for summary judgment, moving parties must show there are no triable issues of fact and they are entitled to judgment without a trial. (Code Civ. Proc., § 437c, subd. (c).) If the motion is brought by a defendant, the defendant has the burden to show that the plaintiffs claims are without merit. Once the defendant has met that burden, the plaintiff has the burden of raising a triable issue of fact. (§ 437c, subd. (o)(2).) "In ruling on the motion, the court must resolve all doubts regarding the existence of triable issues of material fact in favor of the party opposing the motion, must consider all of the evidence, including inferences reasonably drawn from it, and must view the evidence in the light most favorable to the opposing party. [Citation.] [¶] On appeal, the court 'determines de novo "whether an issue of material fact exists and whether the moving party was entitled to summary judgment as a matter

  

of law." ' [Citations.]" (*Hernandez v. KWPH Enterprises* (2004) 116 Cal.App .4th 170, 174-175.)

***6** Medical providers must exercise that degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar circumstances. (*Barris v. County of Los Angeles* (1999) 20 Cal.4th 101, 108, fn. 1; *Alef v. Alta Bates Hospital* (1992) 5 Cal.App.4th 208, 215.) The requisite standard of care in a medical malpractice lawsuit is determined by the applicable standard of care then existing in the same or similar locality under the circumstances. (*Rainer v. Community Memorial Hosp.* (1971) 18 Cal.App.3d 240, 259.) Where medical personnel are accused of negligence, expert testimony must establish the standard of care. (*Barris v. County of Los Angeles, supra,* at p. 108, fn. 1; *Williamson v. Prida* (1999) 75 Cal.App.4th 1417, 1424; *Hanson v. Grode* (1999) 76 Cal.App.4th 601, 606-607.) The proper foundation must be laid for evidence submitted by an expert. (Evid.Code, § 801, subd. (b).)

" '[I]n any medical malpractice action, the plaintiff must establish: "(1) the duty of the professional to use such skill, prudence, and diligence as other members of his profession commonly possess and exercise; (2) a breach of that duty; (3) a proximate causal connection between the negligent conduct and the resulting injury; and (4) actual loss or damage resulting from the professional's negligence." [Citation.]' [Citation.]" (*Hanson v.. Grode, supra,* 76 Cal.App.4th at p. 606.)

In a medical malpractice lawsuit, causation must be proven within a reasonable medical probability based upon competent expert testimony. (*Morgenroth v. Pacific Medical Center, Inc.* (1976) 54 Cal.App.3d 521; *Jones v. Ortho Pharmaceutical Corp.* (1985) 163 Cal.App.3d 396, 403 [distinguishing "probability" from medical "possibility"].)

### 2. *There are triable issues of fact with regard to some defendants.* [4]

4 Ms. Hahn also contends reversal is warranted because the trial court erroneously denied her motion to continue the hearings on the motions for summary judgment so the deposition of Dr. Gruen could have been taken. The declaration accompanying Ms. Hahn's continuance motion showed that Dr. Gruen had recently been designated as an expert and his deposition was needed to address his expected testimony. To be successful on appeal, Ms. Hahn has to show that the trial court abused its discretion in denying her continuance motion. (Code Civ. Proc., § 437c, subd. (h); *Scott v. CIBA Vision Corp.* (1995) 38 Cal.App.4th 307, 326; *Roth v. Rhodes* (1994) 25 Cal.App.4th 530, 547-548.) Although we cannot conclude there was an abuse of discretion, it is a very close call and we are disturbed by the trial court's ruling. The ruling precluded Ms. Hahn from deposing the most critical witness-the physician who performed the first surgery. Further, Dr. Gruen had been belatedly designated as an expert, when at the beginning of the litigation he had refused to answer interrogatories contending the inquiries called for expert testimony. Also, during the entire process, the parties had invested considerable time and resources in trying to resolve the case through mediation. Had any one of the mediations been successful, the deposition would not have been needed. While expediting cases through the system is important, the speedy process should not deprive parties of information vital to their case. On remand, we assume this issue will be revisited and that the trial court will agree with the importance of allowing Dr. Gruen to be deposed, in the interest of justice.

The facts of this case involve two separate surgeries, the discectomy and the subsequent thyroplasty. We conclude triable issues of

  

fact exist with regard to the professional services rendered relevant to the first surgery, but not with regard to the second.

a. *With regard to USC Hospital, Dr. Hart, Dr. Gruen, and USC Neurosurgeons, the declarations submitted by Ms. Hahn raised triable issues of fact.*

We have not detailed the declarations submitted in support of the motions brought by USC Hospital, Dr. Hart, Dr. Gruen, and USC Neurosurgeons. These declarations properly attested to the required standard of care, that this standard was met, and that nothing that was done caused Ms. Hahn's injuries. Thus, the burden switched to Ms. Hahn to raise a triable issue of fact. (Code Civ. Proc., § 437c, subd. (o)(2).)

With regard to the first surgery, Ms. Hahn's theory was as follows: As shown in the MRI, she had a right-sided anomaly that was not diagnosed nor considered by Dr. Gruen or Dr. Hart. Due to the route to be used in performing the surgery, this anomaly created risk of injury. When the anomaly was retracted during surgery, she was injured. The negligent surgical performance and the negligent postoperative care, paralyzed her laryngeal nerve. It also resulted in coughing, choking, aspirating, and an inability to speak or swallow. Had the postoperative care met the standard of care, Ms. Hahn's injury would have been diagnosed and her resulting aspiration problems addressed.

*7 To support these theories, Ms. Hahn presented her declaration, Dr. Ryan's declaration, and Dr. Dayes's declaration. These declarations raised a number of triable issues of fact about the preoperative care, the quality of the surgery performed, as well as the postoperative care.

The facts attested to in Ms. Hahn's declaration showed she was not sent to a specialist after the anomaly was discovered.

Ms. Hahn's declaration, and the declaration of her father, Dr. Ryan, demonstrated the following. While Ms. Hahn was in the hospital, she complained that she could not talk, swallow, or cough and that she was unable to drink or eat without choking. Her vocal cord was paralyzed. She was not visited by Dr. Gruen, as he had gone on vacation. Further, after the surgery, Ms. Hahn was referred to a specialist only after her father intervened and contacted Dr. Gruen. Ms. Hahn's declaration also included an admission by Dr. Gruen that he had provided care below the applicable standard as he told Ms. Hahn that he was " 'sorry' and that he had been 'in denial' as to the seriousness of [her] condition."

Dr. Dayes's declaration provided the required expert testimony. According to Dr. Dayes, the anomaly, as shown in the MRI warranted special attention. The anomaly could create additional pressure on the laryngeal nerve. It warranted a consultation with a specialist prior to surgery, and a laryngoscopy. During surgery, the anomaly required direct visualization, which was the responsibility of Dr. Gruen and Dr. Hart. The failure to diagnose and consider the anomaly during and before surgery, the failure to reconsider the operation site, and the failure to consider using an alternate

route for the surgery fell below the standard of care. The laryngeal nerve was either severed or avulsed during surgery, as the nerve damage suffered by Ms. Hahn was consistent with the presence of an anomaly. Dr. Hart's notes were incomplete. Dr. Hart was responsible for retraction, did not conduct appropriate postoperative care, and discharged Ms. Hahn without properly considering her complaints, diagnosing the problem, or referring her to a specialist. Had the injuries been timely diagnosed, surgery to reconnect the nerve would have been considered.

These declared statements of Dr. Dayes, when combined with those of Ms. Hahn and Dr. Ryan, raise triable issues of fact with regard to whether the care given prior to discectomy, during that surgery, and the postoperative care met the standard of care. These statements contradicted those presented by USC Hospital, Dr. Hart, Dr. Gruen, and USC Neurosurgeons and raised triable issues of fact with regard to breach, causation, and damages as to these defendants.

By this conclusion we are not deciding liability. Rather, we conclude that the dueling declarations created triable issues of fact and Ms. Hahn is entitled to a trial on the merits as against USC Hospital, Dr. Hart, Dr. Gruen, and USC Neurosurgeons.

***8** On appeal Ms. Hahn contends she raised triable issues of fact regarding battery, and concealment. However, as the trial court found, these theories were not included in her complaint (see fn. 2), which framed the issues. (*Scolinos v. Kolts* (1995) 37 Cal.App.4th 635, 639.) Ms. Hahn also argues that her complaint did raise issues with regard to informed consent, and the facts in the declarations she submitted raised triable issues of fact with regard to this theory of medical negligence. (*Cobbs v. Grant* (1972) 8 Cal.3d 229; *Arato v. Avedon* (1993) 5 Cal.4th 1172, 1183.) Even assuming, Ms. Hahn's complaint raised the issue, the declarations were insufficient. Ms. Hahn never stated that had she been properly advised, she would have done something differently. She never established a causal connection between the purported failure and the injury. (*Cobbs v. Grant, supra,* at p. 245.)

*The arguments of USC Hospital, Dr. Hart, Dr. Gruen, and USC Neurosurgeons are not persuasive.*

The trial court sustained most of the evidentiary objections posed by the defendants pertaining to the declarations submitted by Ms. Hahn. On appeal, defendants contend these evidentiary rulings were correct, resulting in an absence of admissible evidence to support Ms. Hahn's theory and her opposition to their motions. We have carefully examined all declarations. With regard to the first surgery and the claims of negligence against defendants USC Hospital, Dr. Hart, Dr. Gruen, and USC Neurosurgeons, defendants' contentions are not persuasive.

These defendants assert Ms. Hahn's supporting declarations failed to demonstrate that the type of injuries suffered by Ms. Hahn could have occurred without

negligence. However, these defendants' declarations failed to address Ms. Hahn's paralysis. Further, even if the surgery itself was performed in a non-negligent manner, Dr. Dayes's declaration adequately raised triable issues of fact as to whether there were postoperative failures that contributed to, aggravated, or failed to alleviate Ms. Hahn's injuries.

These defendants contend Dr. Dayes's declaration is insufficient because he merely states his *personal* opinion, and does not address the standard of care. Although Dr. Dayes does, at times, base a particular conclusion on his personal opinion, other conclusions were not personally based. Dr. Dayes often discussed the standard of care and his expert opinion that this standard was not met.

These defendants contend the trial court properly sustained objections based upon the claim that Dr. Dayes's declaration was vague and ambiguous. However, Ms. Hahn is entitled to all favorable inferences that may reasonably be derived from Dr. Dayes's declaration. (*Hanson v. Grode, supra,* 76 Cal.App.4th at p. 607.) Taken in its entirety, Dr. Dayes's declaration was neither vague nor ambiguous. Further, any portions that were vague or ambiguous were clarified in other portions of Dr. Dayes's declaration, or not vital to her claims.

***9** These defendants also contend Dr. Dayes failed to clearly identify the records he reviewed or relied upon and thus, the foundation for his expert opinions lacked foundation, were incompetent and inadmissible. However, the context of his statements provided sufficient clarity in this regard.[5]

5 USC Hospital and Dr. Hart also contend that Dr. Dayes's declaration did not meet the statutory requirements of Code of Civil Procedure section 2015.5 as his signature was on an attached page and not the declaration itself. These defendants fail to cite to the record to show that this overly technical argument was presented to, and ruled upon by, the trial court.

The trial court erred in granting summary judgment to USC Hospital, Dr. Hart, Dr. Gruen, and USC Neurosurgeons.

b. *With regard to USC Head Neck, there are no triable issues of fact.*

The allegations relating to USC Head Neck all involve those services performed by Dr. Sinha, i.e., those relating to the thyroplasty.

We have not detailed the contents of Dr. Waxs declaration submitted by USC Head Neck, as it was sufficient to place the burden upon Ms. Hahn to raise a triable issue of fact.[6] With regard to USC Head Neck, Ms. Hahn only submitted her declaration and that of her father, Dr. Ryan. These declarations did not raise triable issues of fact.

6 Dr. Wax is an Oregon physician. Ms. Hahn objected to his declaration arguing he lacked the proper qualifications to discuss the standard of care for this locality. Thereafter, USC Head & Neck submitted Dr. Wax's 51-page curriculum vitae and a second declaration declaring that he repeatedly performed the thyroplasty and taught the procedure at an Oregon medical school. At oral argument on the motions, Ms. Hahn's attorney waived any problem with the timeliness of the submission of Dr. Wax's credentials and asked the trial court determine the

> issues on the merits. Counsel did not waive the objections to his qualifications.
>
> Ms. Hahn argues on appeal that Dr. Wax's declaration did not address the standard of care and did not identify the facts he reviewed. Regardless of whether the information provided was sufficient to establish Dr. Wax's ability to attest to the standard of care, the context of his declaration sufficiently described the facts he reviewed and his declaration was sufficient in the area of causation. Dr. Wax specifically declared, "there is no indication in the records or depositions of plaintiffs that Ms. Hahn suffered injury as a result of the thyroplasty procedure." The trial court overruled the objection to this statement. It also overruled the objection to Dr. Wax's statement that "[t]he fact that Ms. Hahn's voice quality improved following the thyroplasty indicates that the surgery performed by Dr. Sinha was successful." Dr. Wax also declared "To a reasonable degree of medical probability, Ms. Hahn did not suffer any injury as a result of the treatment by U.S.C. Head and Neck Group and Dr. Sinha." The trial court sustained the objection to this statement upon Ms. Hahn's objection of lack of foundation and being conclusory. However, this ruling was erroneous. Dr. Wax's declarations and his belatedly submitted curriculum vitae demonstrated that this otolaryngologist had the medical qualifications to address causation after scrutinizing the appropriate medical records. Further, his statement is not conclusory.

First, Ms. Hahn lacks the medical expertise to render medical conclusions and opinions. Ms. Hahn declared that no one used the term "right medialization thyroplasty," nor explained this procedure. However, she did not state in her declaration that she would not have had the procedure had she been so informed.

Second, although Dr. Ryan's statements as a percipient witness (such as that Ms. Hahn did not improve after the thyroplasty) were relevant and admissible, his declaration was also submitted as a medical expert. As an expert, Dr. Ryan was required to declare that his opinions were based upon the standard of practice. His declaration failed in this regard. There was no statement in his declaration that he was addressing the standard of care. Dr. Ryan declared the thyroplasty was not indicated, the silicone injection was the proper treatment for her paralysis, and Dr. Sinha's suggestions for voice therapy and smoking cessation were not correct. However, these opinions were Dr. Ryan's personal statements and not based upon the standard of care and practice. The only statement Dr. Ryan made with regard to the standard of care was that Dr. Wax had failed to provide his (Dr. Wax's) qualifications and Dr. Wax had failed to articulate the standard of care.

Since Ms. Hahn did not present declarations containing facts to raise triable issues of fact with regard to USC Head & Neck, the trial court correctly granted summary judgment with regard to this defendant.

### 3. *The trial court did not abuse its discretion in awarding costs. However, the trial court may wish to revisit the issue upon remand.*

#### a. *The costs awarded to USC Neurosurgeons, USC Head & Neck and Dr. Gruen.*

After judgments were entered, USC Neurosurgeons, USC Head & Neck and Dr. Gruen filed and served a memorandum of costs. Ms. Hahn made a motion to tax. On appeal, Ms. Hahn objects to the ruling that permitted these defendants to recover specified service of process costs. (These defendants had originally requested $2,075.30 for this cost. The trial court taxed such amount by $180.)

***10** "Code of Civil Procedure section 1033.5 sets forth the costs recoverable by the prevailing party. To recover a cost, it must be reasonably necessary to the litigation and reasonable in amount. [Citation.]" (*Thon v. Thompson* (1994) 29 Cal.App.4th 1546, 1548, fn. omitted.) We review a trial court's ruling regarding the recovery of litigation costs for abuse of discretion. (*Ibid.*)

The costs to which Ms. Hahn first objects were associated with obtaining and copying her medical records. She contends the records were unreasonably awarded because she had provided authorizations to obtain her medical records from her workers' compensation carrier and this authorization was sufficient. The trial court concluded it would have been unreasonable to expect defendants to limit their search for records when they did not know if the carrier possessed all relevant items. The trial court did not abuse its discretion in reaching this conclusion.

This cost was awarded to a number of defendants. However, only USC Head & Neck properly obtained summary judgment. On remand, the trial court may need to revisit this award to determine if an apportionment or reallocation is required.

b. *The costs awarded to USC Hospital.*

USC Hospital also filed and served a memorandum of costs, to which Ms. Hahn made a motion to tax. On appeal, Ms. Hahn objects to a ruling permitting the recovery of the costs associated with expenses in taking the deposition of Dr. Hart in Salt Lake City, Utah.

At this juncture, this issue is irrelevant since we have concluded summary judgment was improperly granted to USC Hospital. However, we have addressed it as it may be raised at a subsequent time.

Code of Civil Procedure section 1033.5, subdivision (a)(3) "specifically authorizes reimbursement of travel expenses to attend depositions...." (*Thon v. Thompson, supra,* 29 Cal.App.4th at p. 1548.) The declaration submitted by USC Hospital included a statement of counsel that travel to Utah was necessary. We cannot conclude the trial court abused its discretion in finding that this includes counsel's overnight stay.

## CONCLUSION

The trial court erred in granting summary judgment to the defendants connected to the first surgery (USC Hospital, Dr. Hart, Dr. Gruen, and USC Neurosurgeons) as there are triable issues of fact. The trial court correctly granted summary judgment to defendant USC Head & Neck as its only connection to the facts relate to the second surgery, and Ms. Hahn failed to proffer sufficient medical expert evidence to raise a triable issue of fact. [7]

7 The parties gloss over the agency issues. The parties seem to concede that USC Head & Neck was liable only if Dr. Sinha was negligent with regard to Ms. Hahn's medical care involving the second surgery (the thyroplasty). The parties also seem to concede that USC Hospital and USC Neurosurgeons can be liable

> if there was negligence with regard to care involving the first surgery (the discectomy). The only evidence in the record that we have located comes from Dr. Dayes. He declared that Dr. Hart was "a resident and employee of [USC] hospital." He also declared that "[t]he hospital's personnel and residents[,] including Dr. Hart, did not inform [Ms. Hahn] of the risks of her surgery, did not treat her post-operatively for her paralysis, and did not disclose her paralysis to her." These facts raise a triable issue of fact as to USC Hospital's liability.

The trial court did not abuse its discretion in awarding costs, however, if required, the trial court may revisit the issue upon remand.

## DISPOSITION

The judgment is affirmed with regard to USC Head & Neck. USC Head & Neck is entitled to its costs on appeal. Upon remand, the trial court is to ascertain the costs on appeal. The trial court may, if required, re-address the costs awarded to USC Head & Neck pursuant to Code of Civil Procedure section 1033.5.

***11** The judgments are reversed with regard to all other defendants, USC Hospital, Dr. Hart, Dr. Gruen, and USC Neurosurgeons. With regard to these defendants Ms. Hahn and Thomas Hahn are entitled to costs on appeal. Upon remand, the trial court is to ascertain the costs on appeal.

We concur: KLEIN, P.J., and KITCHING, J.

**All Citations**

Not Reported in Cal.Rptr.3d, 2005 WL 1253907

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# EXHIBIT M

2004 WL 1368205

CHECK OHIO SUPREME COURT RULES FOR REPORTING OF OPINIONS AND WEIGHT OF LEGAL AUTHORITY.

Court of Appeals of Ohio,
Sixth District, Lucas County.

Barbara LEWIS, et al., Appellant
v.
The TOLEDO HOSPITAL, Defendant
and
Michael Moront, M.D. and
Cardiothoracic Surgeons for
Northwest Ohio, Inc., Appellees.

No. L-03-1171.
|
Decided June 18, 2004.

**Synopsis**

**Background:** Patient, who sustained bilateral phrenic nerve injury following open-heart surgery, brought medical malpractice action against surgeon and his employer. The Court of Common Pleas, Lucas County, No. CI-2001-1382, denied patient's motion for directed verdict and entered judgment for surgeon and his employer. Patient appealed.

**Holding:** The Court of Appeals, Knepper, J., held that jury question existed as to whether surgeon breached standard of care when he performed open-heart surgery on patient.

Affirmed.

West Headnotes (1)

**[1] Health**
Questions of Law or Fact and Directed Verdicts

198H Health
198HV Malpractice, Negligence, or Breach of Duty
198HV(G) Actions and Proceedings
198Hk824 Questions of Law or Fact and Directed Verdicts
198Hk825 In General

Jury question existed as to whether surgeon breached standard of care when he performed open-heart surgery on patient, who sustained bilateral phrenic nerve injury following surgery, where fact that surgeon testified that standard of care was not to injure nerves and that patient's nerves were injured did not establish that surgeon committed medical malpractice, expert witnesses provided divergent testimony regarding whether application of ice slush to heart in manner described by surgeon was breach of standard of care, and there was ample testimony that phrenic nerve damage can occur even in absence of open-heart surgery. Rules Civ.Proc., Rule 50(A)(4).

1 Cases that cite this headnote

  

**Attorneys and Law Firms**

Martin W. Williams, for appellant.

James F. Nooney, for appellees.

**Opinion**

KNEPPER, J.

***1** {¶ 1} This is an appeal from the judgment of the Lucas County Court of Common Pleas which denied the motion for directed verdict of appellant, Barbara Lewis, during her trial against appellees, Michael Moront, M.D., and Cardiothoracic Surgeons for Northwest Ohio, Inc. ("Cardiothoracic Surgeons"). For the reasons that follow, we affirm the decision of the trial court.

{¶ 2} Appellant underwent a coronary bypass surgery, on June 19, 2000, which was performed by Dr. Moront, who was employed by Cardiothoracic Surgeons. Following her surgery, appellant had difficulty breathing and was placed on a ventilator for several months. The parties stipulated that appellant's breathing difficulty was due to her sustaining "a bilateral phrenic nerve injury following open-heart cardiac surgery." The phrenic nerves are responsible for diaphragm function. Appellant asserted at trial that a topical ice slush, used at the inception of the surgery to cool her heart, was responsible for her nerve injury. Appellant asserted that Dr. Moront departed from acceptable standards of care in failing to use some method to insulate and protect from injury the nearby phrenic nerves while using the slush.

{¶ 3} At trial, Dr. Moront testified that he had no recollection of using an ice slush and that no indication of such was made in appellant's operative notes. However, even assuming he had used the slush, Dr. Moront testified that according to the manner in which he would have applied the slush, insulation of the phrenic nerves was not necessary. He testified that he only applies ice slush to the anterior of the heart for two to three minutes at the onset of surgery to arrest the heart. The phrenic nerves are not in the anterior area of the heart, but are to the side/back of the heart, outside of the pericardium. Additionally, Dr. Moront testified that there are a number of ways by which the phrenic nerves can be injured other than freezing as a result of contact with ice slush.

{¶4} The experts who testified at trial agreed that phrenic nerve paralysis is a recognized complication and known risk of coronary artery bypass grafting. The expert witnesses also agreed that the most probable and likely cause of appellant's nerve injury was ice slush freezing the phrenic nerves. However, the experts testified that there are a number of ways by which the phrenic nerves can be damaged, other than freezing. Moreover, the experts agree that the risk of injury to the phrenic nerves can never be completely eliminated, regardless of the degree of care and skill exercised by the surgeon. In fact, Dr. Andrew Wechsler, appellant's expert, testified that there are reported cases of phrenic nerve paralysis in patients who have never undergone open-heart surgery.

{¶ 5} The experts, however, disagreed on whether it would be a deviation from the standard of care for a physician to use ice slush and not use some type of insulation over the phrenic nerves. Dr. Brack Hattler testified that Dr. Moront did not breach the standard of care in performing appellant's surgery because he also employs the same method of ice slushing and because using slush "on the anterior surface of the heart carries a very low risk of phrenic nerve injury." Whereas, Dr. Wechsler testified that it would be a departure from the standard of care for any cardiothoracic surgeon to use topical slush to cool the heart, as part of a coronary artery bypass procedure, and not insulate the phrenic nerves. Wechsler, however, also testified that phrenic nerve paralysis is a complication of coronary bypass grafting that can and does occur without regard to surgical care and regardless of whether a surgeon followed accepted methods for performing the surgery.

***2** {¶ 6} Upon completion of the testimony, appellant moved for a directed verdict and argued:

{¶ 7} "Dr. Moront's own testimony * * * [is] that the standard of care requires that you not injure the phrenic nerves. The entire testimony in this case is-including the stipulation, is that she did sustain a bilateral phrenic nerve injury, operative word being injury. * * * [A]ll of the other experts have testified that that injury was the cause of using the ice slushing. So by his very definition, Dr. Moront's very definition, he violated the standard of care because he injured the nerves by use of the ice slushing without protection."

{¶ 8} Appellees responded that the case was not one of res ipsa loquitur and that the standard of care only required Dr. Moront to do all he could to protect and avoid that kind of injury. Appellees further argued:

{¶ 9} "None of the testimony is suggestive that simply by virtue of the fact that the injury occurred there had to have been malpractice. And that's what he was saying that we've agreed to, when his own expert conceded at the outset of his testimony that that wasn't true; that the mere fact of injury does not indicate that there's been malpractice. * * * He conceded that this can and does happen without regard to the propriety of the manner in which the surgery was done. But moreover, even if you assume that that was the import of Dr. Moront's testimony, the testimony of Dr. Hattler is that he complied with accepted standards of care. So at the most it would be a jury issue."

{¶ 10} The trial court denied appellant's motion for directed verdict. The jury ultimately entered a defense verdict. Appellant appeals the decision of the trial court and raises the following sole assignment of error:

{¶ 11} "The trial court erred in denying plaintiff's-[appellant's] motion for directed verdict."

{¶ 12} Specifically, appellant argues that, according to Dr. Moront, the standard of care was simply not to injure the phrenic

  

nerves. Insofar as the parties stipulated that appellant's nerves were injured, appellant argues that Dr. Moront admittedly breached the standard of care owed appellant.

{¶ 13} To prevail in a medical malpractice action, a plaintiff must establish (1) the existence of a duty, (2) a breach of that duty, and (3) proximate causation between the breach of duty and the injury. *Littleton v. Good Samaritan Hospital & Health Center* (1988), 39 Ohio St.3d 86, 92, 529 N.E.2d 449.

{¶ 14} "Under Ohio law, as it has developed, in order to establish medical malpractice, it must be shown by a preponderance of the evidence that the injury complained of was caused by the doing off some particular thing or things that a physician or surgeon of ordinary skill, care and diligence would not have done under like or similar circumstances, or by the failure or omission to do some particular thing or things that such a physician or surgeon would have done under like or similar conditions and circumstances, and that the injury complained of was the direct result of such doing or failing to do some one or more of such particular things." *Bruni v. Tatsumi* (1976), 46 Ohio St.2d 127, 131, 346 N.E.2d 673.

***3** {¶ 15} Civ.R. 50(A) governs when a trial court may grant a motion for directed verdict:

{¶ 16} "(4) When granted on the evidence. When a motion for a directed verdict has been properly made, and the trial court, after construing the evidence most strongly in favor of the party against whom the motion is directed, finds that upon any determinative issue reasonable minds could come to but one conclusion upon the evidence submitted and that conclusion is adverse to such party, the court shall sustain the motion and direct a verdict for the moving party as to that issue."

{¶ 17} In construing the evidence most strongly in favor of the party against whom the motion is directed, the trial court "must neither consider the weight of the evidence nor the credibility of the witnesses." *Strother v. Hutchinson* (1981), 67 Ohio St.2d 282, 284, 423 N.E.2d 467. Additionally, where reasonable minds might reach different conclusions regarding the evidence presented and where there is substantial, competent evidence to support the claim of the party against whom the motion is made, the motion for directed verdict must be denied. *Kroh v. Continental Gen. Tire, Inc.* (2001), 92 Ohio St.3d 30, 31, 748 N.E.2d 36.

{¶ 18} Upon a thorough review of the record and applicable law, we find that appellant was not entitled to a directed verdict. The fact that Dr. Moront testified that the standard of care was not to injure the nerves, and that appellant's phrenic nerves were damaged, do not establish that Dr. Moront committed medical malpractice. Doctors take an oath to "do no harm." Dr. Moront's description of the standard of care is aligned with this oath; however, we agree with appellees that this is not a res ipsa loquitur type of case. Rather, even given Dr. Moront's description of the

  

standard of care, we find that appellant must nevertheless establish that Dr. Moront injured her nerves as a direct result of his failure to do what a surgeon of ordinary skill, care and diligence would have done under like or similar circumstances. See *Bruni,* supra.

{¶ 19} Dr. Wechsler and Dr. Hattler provided divergent testimony regarding whether applying the ice slush to the anterior portion of the heart in the manner described by Dr. Moront, without insulation of the phrenic nerves, was a breach of the standard of care. Additionally, although the experts testified that the use of ice slush was probably the cause of appellant's injury, there was ample testimony that phrenic nerve damage can occur for any number of reasons, even in the absence of open-heart surgery.

{¶ 20} Based on the conflicting testimony, and after construing the evidence most strongly in favor of appellees, we find that reasonable minds could have reached different conclusions regarding the evidence presented. See Civ.R. 50(A)(4); and *Kroh,* supra. We further find that there was substantial, competent evidence to support Dr. Moront's assertion that he did not breach the standard of care when operating on appellant. See *Kroh,* supra. The trial court therefore did not error in denying appellant's motion for directed verdict. Appellant's sole assignment of error is found not well-taken.

***4** {¶ 21} On consideration whereof, the court finds substantial justice has been done the party complaining and the judgment of the Lucas County Court of Common Pleas is affirmed. Appellant is ordered to pay the court costs of this appeal.

JUDGMENT AFFIRMED.

A certified copy of this entry shall constitute the mandate pursuant to App.R. 27. See, also, 6th Dist.Loc.App.R. 4, amended 1/1/98.

PETER M. HANDWORK, P.J., RICHARD W. KNEPPER and MARK L. PIETRYKOWSKI, JJ., concur.

**All Citations**

Not Reported in N.E.2d, 2004 WL 1368205, 2004 -Ohio- 3154

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# EXHIBIT N

2002 WL 1357099
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8.1105 and 8.1110, 8.1115)
Only the Westlaw citation
is currently available.



Court of Appeal, Second
District, Division 4, California.

Ciai AU, Plaintiff and Appellant,
v.
Raymond W.P. LEUNG,
Defendant and Respondent.

No. B151250.
|
(Super.Ct.No. GC025112).
|
June 20, 2002.

Patient sued physician who had performed thyroidectomy for medical malpractice. The Superior Court of Los Angeles County, No. GC025112, J. Michael Byrne, J., granted physician's motion for summary judgment. Patient appealed. The Court of Appeal, Epstein, Acting P.J., held that: (1) patient presented no evidence that physician was professionally negligent; (2) physician warned patient of possible risks of surgery; (3) trial court did not abuse its discretion by refusing to continue summary judgment hearing in order to allow patient to take physician's deposition; and (4) trial court did not abuse its discretion in denying patient's motion for reconsideration based on newly discovered evidence.

Affirmed.

West Headnotes (4)

**[1] Health**
Surgical Operations in General
198H Health
198HV Malpractice, Negligence, or Breach of Duty
198HV(G) Actions and Proceedings
198Hk815 Evidence
198Hk823 Weight and Sufficiency, Particular Cases
198Hk823(5) Surgical Operations in General

Physician who performed thyroidectomy was not professionally negligent, though following surgery patient was diagnosed as having possible laryngeal nerve injury and right vocal chord paralysis, where physician stated that in his professional opinion he did not cause or contribute to the injuries, and patient did not present expert medical testimony that disputed physician's statement.

Cases that cite this headnote

**[2] Health**
Surgical Procedures
198H Health
198HVI Consent of Patient and Substituted Judgment
198Hk904 Consent of Patient

198Hk908 Surgical Procedures

Physician did not fail to advise and warn patient, who after surgery was diagnosed as having possible laryngeal nerve injury and right vocal chord paralysis, of possible consequences and risks of thyroidectomy, where physician when he recommended thyroidectomy warned patient of the possible risks and complications of the procedure including laryngeal nerve injury resulting in hoarseness, and patient signed two informed consent forms acknowledging risks and complications of surgery and anesthesia including paralysis, hoarseness, injury to vocal cords, and nerve injury.

Cases that cite this headnote

**[3] Judgment**

Hearing and Determination

228 Judgment
228V On Motion or Summary Proceeding
228k182 Motion or Other Application
228k186 Hearing and Determination

Trial court in medical malpractice action did not abuse its discretion in denying patient's motion to continue summary judgment hearing in order to depose treating physician, where patient did not file a response to the summary judgment motion, and provided no indication of what facts he expected to obtain from physician, or why those facts were essential to oppose the summary judgment. West's Ann.Cal.C.C.P. § 437c subd. (h).

Cases that cite this headnote

**[4] Judgment**

Hearing and Determination

228 Judgment
228V On Motion or Summary Proceeding
228k182 Motion or Other Application
228k186 Hearing and Determination

Trial court did not abuse its discretion, in medical malpractice action, by denying plaintiff's motion to reconsider its summary judgment for physician based on patient's discovery of new evidence, where new evidence was a discrepancy in patient's copy of one of his medical records and physician's copy of that record, patient's counsel knew of the discrepancy before summary judgment hearing date, and counsel chose not to present evidence of the allegedly altered record because he erroneously assumed he would be able to obtain a continuance in the summary judgment hearing to take physician's deposition without it. West's Ann.Cal.C.C.P. § 1008 subd. (a).

Cases that cite this headnote

APPEAL from a judgment of the Superior Court of Los Angeles County, J. Michael Byrne, Judge. Affirmed.

**Attorneys and Law Firms**

Perliss & Gross and Kenneth I. Gross, for Plaintiff and Appellant.

Bonne, Bridges, Mueller, O'Keefe & Nichols, Mark B. Connely and Alisa R. Knight, for Defendant and Respondent.

**Opinion**

EPSTEIN, Acting P.J.

***1** Plaintiff Ciai Au challenges the trial court's grant of summary judgment in his medical malpractice action. We find no abuse of discretion in the trial court's denial of a continuance of the hearing on the summary judgment motion, and find that on the record presented, there are no triable issues of material fact. Consequently, defendant Raymond Leung is entitled to judgment as a matter of law. That is the judgment he received, which we affirm.

## FACTUAL AND PROCEDURAL SUMMARY

In January 1999, Ciai Au sought treatment from Dr. Raymond Leung for an enlarged thyroid. Mr. Au's sister, Nu Tran, accompanied him on this and subsequent visits to Dr. Leung. Dr. Leung prescribed thyroid suppression medication. Mr. Au was unresponsive to the medication, and Dr. Leung recommended a subtotal thyroidectomy.

The surgery was performed on March 23, 1999. After the surgery, Mr. Au experienced throat and neck pain and hoarseness. The pain decreased within a few weeks, but the hoarseness persisted.

Mr. Au consulted an ear, nose and throat specialist, who concluded he had right total vocal chord paralysis. The doctor recommended laryngoplasty and vocal chord surgery. Mr. Au did not undergo the recommended surgery.

On May 5, 2000, Mr. Au brought this action for medical malpractice and lack of informed consent against Dr. Leung, Alpha Omega Multispecialty Medical Group, and Pomona Valley Ambulatory Surgical Center. Dr. Leung answered in June 2000, and deposed the plaintiff and his sister in October 2000. On December 20, 2000, the court set a trial date of May 14, 2001.

Defendant Pomona Valley moved for summary judgment, with a hearing date of March 22. Then on March 1, 2001, Dr. Leung moved for summary judgment, with a hearing date of April 13, 2001. (The parties later stipulated to have both summary judgment motions heard on April 13.) On March 2, plaintiff noticed Dr. Leung's deposition for March 12. Dr. Leung's counsel informed plaintiff that Dr. Leung was out of town and unavailable on that date. The deposition was rescheduled for March 22, but on March 20, Dr. Leung's counsel asked to reschedule. Plaintiff's counsel persistently sought a deposition date, and on April 3, Dr. Leung's counsel proposed five possible dates, all of which

  

were after the summary judgment hearing date, and three of which were after the date set for trial.

Plaintiff did not file opposition to the summary judgment motion. He filed a request to continue the hearing on the summary judgment motion, on the ground that he needed to take Dr. Leung's deposition in order to present evidence in opposition to the motion. The trial court denied the request, and granted the motion for summary judgment. Plaintiff moved for reconsideration, on the ground of newly discovered evidence that plaintiff's medical records had been altered. The motion was denied.

This is a timely appeal from the judgment.

## DISCUSSION

### I

Plaintiff claims the court erred in granting summary judgment because the evidence presented showed the existence of triable issues of material fact. We disagree.

***2** To be entitled to summary judgment, a defendant must establish that a cause of action has no merit by showing that one or more of the elements of the cause of action cannot be separately established, or that there is a complete defense to that cause of action. (Code Civ. Proc., § 437c, subd. (o)(2).)[1] Once the defendant makes that showing, the burden shifts to the plaintiff to show that a triable issue of one or more material facts exists as to that cause of action or defense thereto. (*Ibid.*)

1 All statutory references are to the Code of Civil Procedure unless otherwise indicated.

Plaintiff's first cause of action was for professional negligence. He alleged that defendants "negligently failed to possess and exercise, in both diagnosis and treatment, that reasonable degree of knowledge and skill that is ordinarily possessed and exercised by surgeons or other health care providers in the same or similar locality in similar circumstances, in that, among other things, defendants caused plaintiff to sustain paralysis and numbness in the affected areas."

Expert medical testimony is required to establish the appropriate standard of care. (*Selden v. Dinner* (1993) 17 Cal.App.4th 166, 173, 21 Cal.Rptr.2d 153.) The standard of care against which the acts of a medical professional are to be measured is the basic issue in a malpractice action, and can only be proved by the testimony of experts. (*Id.* at p. 174, 21 Cal.Rptr.2d 153.)

In support of his motion for summary judgment, Dr. Leung submitted his own declaration. He set out his qualifications as a medical expert, including his education, training, and experience as a surgeon, and his familiarity with the standard of practice for general surgeons practicing in Southern California. Based on plaintiff's medical records and Dr. Leung's education, training, and experience as a surgeon, he stated his opinion that the care and treatment

he provided to plaintiff "was within the applicable standard of practice for general surgeons in the community practicing under the same or similar circumstances." He first provided the appropriate medication, and only after non-intrusive measures proved fruitless did he recommend a thyroidectomy. The surgery was performed without complications or incident. When Dr. Leung diagnosed plaintiff with possible laryngeal nerve injury after the surgery, he immediately referred plaintiff to a specialist to determine the appropriate method of treatment. Based on these medical records and Dr. Leung's expert qualifications, it was his professional opinion that the care and treatment he provided to plaintiff "did not cause or contribute, within a reasonable degree of medical probability, to any of the injuries alleged by the plaintiff."

**[1]** With this evidence, Dr. Leung met his burden of showing that plaintiff cannot establish two necessary elements of his cause of action for professional negligence: that Dr. Leung's treatment of plaintiff was below the standard of care for a medical professional, and that Dr. Leung's care and treatment was the cause of plaintiff's injuries. The burden then shifted to plaintiff to show that a triable issue of material fact exists as to that cause of action. (§ 437c, subd. (o)(2).) Plaintiff presented no evidence in opposition to the summary judgment motion, and thus failed to meet his burden. On the record before it, the trial court correctly concluded that plaintiff could not establish his cause of action for professional negligence.

***3** Plaintiff's second cause of action alleged that Dr. Leung failed to advise and warn him of the possible consequences and dangers involved in the proposed treatment so that plaintiff could make an intelligent and informed choice. In his declaration in support of the summary judgment motion, Dr. Leung stated that at the time he recommended plaintiff undergo a subtotal thyroidectomy, he "discussed the risks and complications of the procedure, including possible laryngeal nerve injury resulting in hoarseness." He also stated that prior to the surgery, plaintiff spoke with him and the anesthesiologist and signed an informed consent document indicating that the risks and complications of surgery and anesthesia had been discussed with him.

**[2]** Dr. Leung submitted two informed consent forms, signed by plaintiff on the date of the surgery, in which plaintiff acknowledged that the risks and complications of surgery and anesthesia had been discussed and that he understood these risks and complications. Specifically mentioned as risks on the "Consent for Procedure: Anesthesia" were paralysis, sore throat, and hoarseness. The second consent form was titled "Consent to Operation, Administration of Anesthetics and Rendering of Other Medical Services, Including Consent for Transfusion(s) and Release of Records." Paragraph 8 of this form provided in part: "In signing this consent, I am indicating that I have adequately discussed with my surgeon the proposed operation and any alternative which I may have to same." Paragraph 9 was labeled "Informed Consent for Anesthesia,"

  

and provided: "Modern anesthesia is safe and usually well tolerated. However, even in experienced and competent hands, complications can occur. Minor problems include nausea and vomiting, headache, and injury to vocal cords, teeth, or dental work. Serious complications include nerve injury, damage to one or more of the vital organs, even major disability or death. Other complications can occur." The form also encouraged the patient to discuss the details of the anesthesia and its risks with the anesthesiologist prior to the surgery.

Plaintiff acknowledged in his deposition that he remembered reading both consent forms before signing them. With this evidence, Dr. Leung established that he obtained plaintiff's informed consent to the surgery. The burden then shifted to plaintiff to show the existence of a triable issue of fact.

As we explained, plaintiff filed no opposition to the summary judgment motion, and therefore presented no evidence. He relies, however, on portions of his deposition, which were included in support of Dr. Leung's motion. Plaintiff was asked at his deposition what Dr. Leung told him about the surgery when he recommended that procedure. Plaintiff said he remembered Dr. Leung telling him he needed surgery, that he would have to go into the hospital to have it done, and that he was going to be under general anesthesia for the surgery. But plaintiff said he did not remember any other details about the conversation, nor did he remember speaking to Dr. Leung at the surgical center before he went into surgery.

***4** Plaintiff's failure to recall the details of the physician's explanation does not contradict Dr. Leung's evidence that he told plaintiff of the risks of surgery, and that plaintiff read and signed forms indicating that he had been informed of the risks of the surgery and anesthesia, and with that knowledge was consenting to the procedure. Nor is a triable issue of fact presented by the deposition of plaintiff's sister, in which she stated that at the time Dr. Leung recommended that plaintiff undergo surgery, he did not "explain much."

Based on the uncontradicted evidence before it, the trial court properly granted summary judgment in favor of Dr. Leung.

II

Appellant claims the court abused its discretion in denying his motion to continue the hearing on the summary judgment motion in order to complete discovery. Section 437c, subdivision (h) provides: "If it appears from the affidavits submitted in opposition to a motion for summary judgment ... that facts essential to justify opposition may exist but cannot, for reasons stated, then be presented, the court shall deny the motion, or order a continuance to permit affidavits to be obtained or discovery to be had or may make any other order as may be just."

It is not sufficient under the statute merely to indicate that further discovery or investigation is contemplated. The statute makes it a condition that the party moving

  

for a continuance show that " 'facts essential to justify opposition may exist.' " (*Roth v. Rhodes* (1994) 25 Cal.App.4th 530, 548, 30 Cal.Rptr.2d 706.) In *Roth,* the party seeking a continuance submitted a declaration indicating that two depositions remained to be completed, and that the expert opinions had not yet been received. The court held this was inadequate: "[T]here is no statement which suggests what facts might exist to support the oppositions to the motions. The trial court was fully justified in finding the declaration insufficient to support a continuance." (*Ibid.*)

**[3]** In our case, plaintiff's showing was even weaker. In support of the request for continuance, plaintiff's counsel submitted a declaration setting forth the following chronology: Dr. Leung filed his motion for summary judgment on March 1, 2001, with a hearing date of April 13. On March 2, plaintiff noticed Dr. Leung's deposition for March 12. He was unavailable for that date, and for the rescheduled date of March 22. As of March 30, when plaintiff moved to continue the summary judgment hearing, plaintiff had been unable to confirm a date for Dr. Leung's deposition, despite repeated telephone calls to opposing counsel.

Plaintiff's counsel then stated: "I believe that plaintiff may be able to present evidence in opposition to Defendants' motions for summary judgment after taking the deposition of Defendant Leung." That is the full extent of plaintiff's showing that "facts essential to justify opposition may exist but cannot, for reasons stated, then be presented, ..." (§ 437c, subd. (h).) He gave no indication of what facts he expected to obtain from Dr. Leung, or why those facts were essential to oppose the summary judgment. He gave no explanation why he could not oppose the motion with evidence from his own expert, or with declarations from plaintiff and plaintiff's sister. Without more, we find no abuse of discretion in the trial court's denial of a continuance.

***5** Section 437c, subdivision (h) includes a requirement that the party seeking a continuance file a response to the summary judgment motion: the explanatory affidavits are to be "submitted in opposition to a motion for summary judgment...." Plaintiff's failure to comply with this response requirement also supports the trial court's denial of a continuance. (See *Haskel, Inc. v. Superior Court* (1995) 33 Cal.App.4th 963, 976, fn. 11, 39 Cal.Rptr.2d 520.)

III

Plaintiff claims the court erred in denying his motion for reconsideration, based on evidence that plaintiff's medical records had been altered. Once again, he has failed to meet the statutory requirements for the relief sought.

Under section 1008, subdivision (a), a party whose application for an order has been denied may, "within 10 days after service upon the party of written notice of entry of the order and based upon new or different facts, circumstances, or law, make application to the same judge or court that made the order, to reconsider the matter

  

and modify, amend, or revoke the prior order. The party making the application shall state by affidavit what application was made before, when and to what judge, what order or decisions were made, and what new or different facts, circumstances, or law are claimed to be shown." "The moving party must provide the trial court with a satisfactory explanation as to why he or she failed to produce the evidence at an earlier time." (*Lucas v. Santa Maria Public Airport Dist.* (1995) 39 Cal.App.4th 1017, 1028, 46 Cal.Rptr.2d 177.)

Plaintiff's motion was made on the ground that he had "new evidence" not presented in support of his motion to continue the summary judgment hearing. The new evidence was a discrepancy between the copy of plaintiff's March 17, 1999 medical record, which Dr. Leung attached as an exhibit to his summary judgment motion, and the copy of the medical record of the same date in plaintiff's file. On Dr. Leung's copy was the handwritten notation: "Discussed risk and complications of surgery since medical therapy not working for him including recurrent laryngeal nerve injury causing hoarseness. Patient's sister concerned about this. I told her very little chance of this since I've done this kind of surgery many times." Plaintiff's copy did not contain that notation. Plaintiff's counsel believed that proper identification and authentication of Dr. Leung's copy of the medical records through Dr. Leung's deposition "would be sufficient to raise a triable issue of material fact on the issue of informed consent. Consequently, there is a likelihood that the deposition of defendant may result in admissible evidence necessary to oppose defendant's motion for summary judgment."

Plaintiff's counsel noticed the discrepancy between the two records on March 7, 2001, before his motion to continue the summary judgment hearing. Unfortunately, he did not present this evidence in his motion for a continuance, or in his affidavit in support of that motion. Nor did he provide a satisfactory explanation for failing to produce the evidence at an earlier time. According to counsel, "I did not disclose the existence of the evidence of the possibility that plaintiff's medical records had been altered at that time because I thought that the deposition of defendant would be scheduled prior to the date of the hearing and therefore we would still be able to submit evidence from the deposition at the hearing; I also believed that given what had occurred with regard to the scheduling of the deposition, and the obvious relevance of the deposition to the issues involved in this case, that the Court would grant a continuance of the hearing to allow the deposition to be taken."

*6 **[4]** Plaintiff's counsel chose not to present evidence of the allegedly altered medical record in support of his motion, based on his erroneous assumption it would be obvious to the trial court without this additional evidence that plaintiff needed to take Dr. Leung's deposition in order to oppose the summary judgment motion. This was a tactical choice. The necessity for Dr. Leung's deposition was not obvious to the trial court, and counsel did not provide a satisfactory explanation for his decision

to withhold this evidence which he had available at the time he filed his motion to continue the hearing. On the record presented, the trial court did not abuse its discretion in denying plaintiff's motion for reconsideration.

DISPOSITION

The judgment is affirmed.

We concur: HASTINGS and CURRY, JJ.

**All Citations**

Not Reported in Cal.Rptr.2d, 2002 WL 1357099

# EXHIBIT O

Chris A. Bergstrom
Kitty L. Groh
Jeffrey J. Short
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July 9, 2012

Richard Carpenter, M.D., Registered Agent
Mid-Michigan Ear, Nose and Throat, P.C.
1500 Abbott Road, Suite 400
East Lansing, MI 48823-1956

*CERTIFIED - RETURN RECEIPT*
*U. S. MAIL - REGULAR*

Re: Notice of Intent to File a Claim and Lawsuit Pursuant to MCL 600.2912b, on behalf of Patricia Merchand

Dear Dr. Carpenter:

Enclosed is a copy of our Notice of Intent to File a Claim and Lawsuit Pursuant to MCL 600.2912b, on behalf of Patricia Merchand. Please forward a copy of this letter and enclosed Notice to your employer and your insurance company.

Very truly yours,

FARHAT & STORY, P.C.

Kitty L. Groh

dca
Enclosure

**NOTICE OF INTENT TO FILE A CLAIM AND LAWSUIT PURSUANT TO MCL 600.2912b**

Notice if hereby given by Patricia Merchand, by her legal counsel, Farhat & Story, P.C., pursuant to MCL600.2912b, of her intent to file a claim and lawsuit against Richard L. Carpenter, M.D., and Mid-Michigan Ear, Nose and Throat, P.C., a domestic professional service corporation, involving the care and treatment provided to Patricia Merchand in 2010.

Richard L. Carpenter, M.D., is a physician specializing in otolaryngology, licensed by the State of Michigan. The American Academy of Otolaryngology - Head and Neck Surgery lists Richard L. Carpenter, as Board Certified with the American Board of Otolaryngology with no subspecialties. The American Board of Medical Specialties also lists Dr. Carpenter as holding a Primary Certificate in Otolaryngology - General with the American Board of Otolaryngology with no subspecialties. The American Medical Association lists Richard Lee Carpenter, M.D., as a member under the Primary Speciality of Otolaryngology. The Sparrow Hospital website states Richard Carpenter, M.D., is Board Certified by the American Board Otolaryngology with the specialty of otolaryngology. Mid-Michigan Ear, Nose and Throat, P.C. website states Dr. Carpenter is a certified member of the American Board of Otolaryngology Head and Neck Surgery and practices as a general otolaryngologist.

At all times pertinent hereto, Richard L. Carpenter, M.D., was an employee, agent, or servant or ostensible and/or apparent agent, and/or agent by estoppel of Mid-Michigan Ear, Nose and Throat, P.C.

Patricia Merchand requested that Dr. Carpenter and Mid-Michigan Ear, Nose and Throat, P.C., provide her with a complete copy of her records. However, they only produced an

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incomplete set of her records. Therefore, Patricia Merchand and her legal counsel's ability to prepare this Notice is impaired based on the lack of records.

## I. FACTUAL BASIS

On June 28, 2010, Patricia Merchand was evaluated by Richard Carpenter, M.D., at Mid-Michigan Ear, Nose and Throat, P.C. Dr. Carpenter's records state that Patricia Merchand had a history of swelling in the right submandibular area that had been present for about a month on and off. He noted that it swells up and then goes down. He stated that she had no real pain with this and that it happens after eating. The record states that she had not noted any stones or blockage. The record notes that evaluation of the salivary glands did not reveal any abnormalities. There was no evidence of erythema or edema of the tongue, lips or gingiva noted. No abnormal masses or lesions were noted. The recorded impression was intermittent right sialadenitis in the submandibular area. Dr. Carpenter ordered a CT scan, Keflex 500 mg QID and fluids. He instructed Patricia Merchand to return on July 12, 2012.

On or about June 30, 2010, a CT of the neck with contrast was performed that revealed mild right submandibular gland swelling noted to be consistent with sialadenitis. No evidence of a neck mass, adenopathy, or sialolith in Wharton's Duct on the right was identified.

On July 12, 2010, Patricia Merchand was evaluated by Richard Carpenter, M.D. at Mid-Michigan Ear, Nose and Throat, P.C. He stated in his record for July 12, 2012 that Patricia Merchand had a history of chronic sialadenitis of the right submandibular gland that had been present for four months and increasing in severity. Dr. Carpenter noted in the record that Patricia Merchand had been on Keflex several times, which had not resolved the problem. Prior to this

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date, Patricia Merchand had only received one prescription for Keflex. Richard Carpenter, M.D. noted that Patricia Merchand continued to having swelling daily that was painful. Richard Carpenter, M.D. noted that the CT scan demonstrated chronic sialadenitis of the right submandibular gland. The CT did not demonstrate chronic sialadenitis of the right submandibular gland. On July 12, 2010, Richard Carpenter, M.D. advised Patricia Merchand that she had multiple stones of the saliva gland and recommended she undergo a right submandibular gland excision. Richard Carpenter, M.D. advised her that if she did not undergo surgery to remove the multiple stones and right submandibular gland, that she could develop facial paralysis and a facial droop. Richard Carpenter, M.D. did not advise her that there were other treatment plans and options available and other medications. He did not advise her that there were other less invasive treatments and surgical options. He did not obtain adequate pre-operative consent including advising Patricia Merchand of the risks of surgery and the alternatives to surgery. He did not advise Patricia Merchand that he might damage the nerves to her face and tongue during surgery. He scheduled the surgery for August 3, 2010.

On July 19, 2010, Patricia Merchand underwent manual extraction of one stone of the submandibular gland by Martin Tuck, D.D.S., M.S.

Patricia Merchand advised Richard Carpenter, M.D. that Dr. Tuck had manually extracted a stone of the submandibular gland. Richard Carpenter, M.D. advised her that she needed to undergo surgery to remove the submandibular gland and other stones.

On or about August 2, 2010, Richard Carpenter, M.D. dictated the history and physical for the planned surgery at Sparrow Hospital on August 3, 2010 and stated that the swelling on the right submandibular vein had been present for about three months and that she had no real pain.

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The impression stated was mass right submandibular vein. There was no mass of the right submandibular gland or vein.

On August 3, 2010, Richard Carpenter, M.D. performed an excision of the right submandibular gland. In the Operative Report he states that Patricia Merchand has had recurrent sialadenitis and stones, which have been removed in the office. He stated that she continued to have stones and swelling, pain, pressure which were not responding to the antibiotic therapy.

Patricia Merchand did not have recurrent sialadenitis and stones. She did not have any stones. Richard Carpenter, M.D. had not removed any stones prior to the day of surgery or on the day of the surgery. Richard Carpenter, M.D. did not remove any submandibular gland stones in his office.

Richard Carpenter, M.D. performed surgery on August 3, 2010. In his Operative Report, Richard Carpenter, M.D. noted identifying the right mandibular branch of the nerves of the face and tongue and retracting it superiorly. He did not locate, identify or protect the other nerves for the face and tongue including, but not limited to, the submandibular branch nerves, the lingual nerve, the sensory nerves or the hypoglossal nerve. He described removing the entire submandibular gland, a stone and a duct. He noted that the stone extruded through the duct and that it was removed. He did not properly inspect the operative field or the nerves including, but not limited to, the submandibular branch nerves, the lingual nerve, the sensory nerves or the hypoglossal nerve to ascertain whether they were functioning or whether they had been injured during the surgery. Richard Carpenter, M.D. submitted the specimen, which he described as the right submandibular gland and a stone, to the pathology department at Sparrow Hospital. The pathologist reported that there were no calculi, masses, nodules, lesions or stones.



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Richard Carpenter, M.D. did not remove any stones during surgery. He did not advise Patricia Merchand that there were no stones or that he did not remove any stones during the surgery. During surgery he injured the nerves for the face and tongue including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, sensory nerves and the hypoglossal nerve. On August 3, 2010, Dr. Carpenter wrote Patricia Merchand a prescription for Keflex. Following the surgery, Patricia Merchand developed severe swelling of her neck to the extent that she felt her incision was going to rip open. Patricia Merchand left a message for Dr. Carpenter on or about August 11, 2010 advising him of the severe swelling. Patricia Merchand received a return call from Dr. Carpenter's office and was advised that she could experience swelling of her neck for up to two years. Dr. Carpenter wrote a prescription for Keflex.

The swelling of the neck continued to increase and on or about August 14, the surgical incision on her neck burst open. Patricia Merchand contacted Dr. Carpenter's office, Mid-Michigan Ear, Nose and Throat, P.C. The on-call physician, Dr. Richardson, contacted her and advised her to take it easy and to present to the office the following Monday to see Dr. Carpenter.

On or about August 15, 2010, Patricia Merchand's condition and infection worsened. Patricia Merchand again called Mid-Michigan Ear, Nose and Throat, P.C., she spoke to Dr. Richardson and advised him that she was worse and the surgical wound was infected. Dr. Richardson again instructed her to take it easy and to present to the office to see Dr. Carpenter on August 16, 2010.

On August 16, 2010, Patricia Merchand presented to see Dr. Carpenter at Mid-Michigan Ear, Nose and Throat, P.C. He placed a drain in the incision. After removing fluid, he re-bandaged the wound.



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On August 18, 2010, Patricia Merchand returned to see Dr. Carpenter. The incision was still open. Dr. Carpenter again drained out fluid from the surgical wound. Dr. Carpenter attempted to cauterize the wound with silver nitrate. He prescribed a 10-day supply of Keflex. He recommended Neosporin for the wound. Patricia Merchand advised him that she was starting to bite the back of her tongue. He advised her that it was part of the healing process and it would take one to two years to heal.

The infection and/or open gapping surgical wound continued to worsen. A red ring developed around the surgical incision. Patricia Merchand continued to experience drainage from the surgical incision.

Patricia Merchand returned to see Dr. Carpenter on August 23, 2010. He noted that there was no infection but that there was a seroma which continued to drain. Patricia Merchand requested a different antibiotic. He prescribed Septra/sulfamethoxazole DS1 BID and cortisporin for the wound.

Patricia Merchand returned to see Dr. Carpenter on August 30, 2010. He advised her to continue to use peroxide on the wound daily.

Patricia Merchand returned to see Richard Carpenter, M.D. on September 13, 2010. The infection and/or open gapping wound was starting to slowly improve with the sulfamethoxazole. She advised him that she was still biting her tongue and he told her that was part of the healing process and would taken one to two years to heal.

On March 7, 2011, Patricia Merchand returned to see Dr. Carpenter. She advised him that she still did not feel right and she still was biting the back of her tongue. Richard Carpenter, M.D. again advised her it was part of the healing process.



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Patricia Merchand began developing difficulty talking and spit was collecting at the right side of her mouth. She noticed that her tongue was developing wrinkling and pulsations. She began experiencing difficulty moving her tongue, paralysis of the tongue, disfigurement of the tongue and pain.

She returned to see her primary care physician, Kay McLaughlin, D.O., on May 10, 2012 for the abnormalities of her tongue. She ordered MRIs. The neck MRI revealed denervation (nerve damage) of the right side of the tongue.

On June 5, 2012, Patricia Merchand was evaluated by an otolaryngologist, Shannon Radgens, D.O. Examination revealed multiple abnormalities of the tongue including paralysis, poor tongue protrusion, weakness and fasciculations of the tongue. She was advised that the nerves in her face including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, sensory nerves and the hypoglossal nerve, had been damaged during the surgery performed by Dr. Carpenter on August 3, 2010. Dr. Radgens advised her that it was unlikely that she would be a candidate for surgery to repair the damage to the injury to her nerves for her face and tongue due to the passage of time from the original injury.

## II. APPLICABLE STANDARD OF CARE FOR RICHARD CARPENTER, M.D. AND ACTIONS REQUIRED TO ACHIEVE COMPLIANCE WITH THE STANDARD OF CARE

At all times pertinent hereto, Richard Carpenter, M.D., upon information and believe, was board certified in otolaryngology and, as such, provided care and treatment to Patricia Merchand in his capacity as a specialist in otolaryngology. In Michigan, the standard of care for a specialist in otolaryngology, including that for a board-certified otolaryngology physician, is a national

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standard of care. Since Dr. Carpenter was specializing in otolaryngology in 2010, and since he is board certified in otolaryngology, he owed a duty to Patricia Merchand to provide care and treatment that a reasonably prudent specialist in otolaryngology and a reasonably prudent board-certified otolaryngology physician of ordinary learning, judgment or skill under the same or similar circumstances would and, to achieve compliance with the standard of care, he was required to do the following:

1. To obtain a proper history and to accurately record the history.
2. To perform a proper and accurate physical examination and record the findings.
3. To formulate a proper differential diagnosis and diagnosis.
4. To properly treat Patricia Merchand.
5. To properly assess whether Patricia Merchand had an infection and the type of infection and to treat it with proper antibiotics and medications.
6. To prescribe appropriate antibiotics and medications including, but not limited to, anti-staphylococcal, clindamycin, NSAIDs.
7. To accurately record the antibiotics prescribed and the number of antibiotic courses.
8. To properly obtain and record Patricia Merchand's history of pain and duration of symptoms.
9. To properly record the treatment of Patricia Merchand and the prescriptions of antibiotics.
10. To maintain accurate treatment records.
11. To properly review the CT performed on June 30, 2010 and the radiologist's report of the CT.
12. To properly note that the CT revealed mild right submandibular gland swelling without any evidence of stones or masses.

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13. Not to chart that he removed multiple stones from Patricia Merchand in this office, when he had not removed any.

14. Not to chart that Patricia Merchand had been treated with multiple courses of antibiotics when he had only treated her with one prescription of Keflex.

15. To advise and engage in a conservative treatment plan for Patricia Merchand which included watchful waiting.

16. To advise Patricia Merchand of the available treatment options and recommend that conservative treatments available including, but not limited to, warm compresses, massages of the saliva gland and surrounding anatomy, manual manipulation/extraction of the stones of the submandibular gland and various items to stimulate the submandibular gland and saliva products such as lemon drops and not to recommend or perform surgery without instituting these treatments.

17. Not to perform surgery prior to treatment with anti-staphylococcal medications and antibiotics such as clindamycin.

18. To re-evaluate and re-assess Patricia Merchand after the one stone of the submandibular gland was found and removed by Martin Tuck, D.D.S, to determine whether any further treatment was necessary.

19. To postpone the surgery scheduled for August 3, 2010, after learning that Martin Tuck, D.D.S. found and removed one stone and to re-assess whether any further surgery or treatment was necessary.

20. Not to prematurely perform surgery on August 3, 2010.

21. Not to perform a surgical removal of the right submandibular gland on August 3, 2010, which was unnecessary.

22. To obtain adequate pre-operative informed consent including advising the patient of the risks of surgery, the likelihood of said risks and the alternatives to surgery.

23. To assess Patricia Merchand for inflammation and/or infection.

24. To obtain cultures and laboratory tests prior to performing surgery.

25. To properly palpate the tongue, submandibular gland and surrounding anatomy prior to recommending or performing surgery.

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26. To attempt manual manipulation and/or squeezing in an attempt to remove the stone of the submandibular gland.

27. To order and obtain an ultrasound and x-rays of the submandibular gland prior to performing surgery.

28. To locate stones before surgery and, if unable to do so, not to schedule and perform surgery.

29. Not to schedule or perform surgery when no stones could be identified.

30. To drain the submandibular gland prior to recommending scheduling or performing surgery.

31. If a decision was made to proceed with a surgical procedure for the mild sialademitis, to proceed with a different type of procedures, e.g., dilation of the duct, marsupialization of the duct, fine-needle aspiration, sialendoscopy and/or refer Patricia Merchand to a different physician or institution so these procedures could be performed.

32. To properly perform the surgery on August 3, 2010 and to make a proper incision in a fashion that would not result in injury to the nerves for the face and tongue, including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, the sensory nerves and the hypoglossal nerve.

33. To properly position Patricia Merchand and her head and neck during the surgery.

34. To properly identify the correct location for the incision and to make all incisions in the proper location, plane and in a proper fashion.

35. To properly utilize the surgical instruments including, but not limited to, scalpels, retractors, cautery and clamps on August 3, 2010, in a manner that would not injure the nerves for the face and the tongue including, but not limited to, the marginal mandibular branch nerves, the lingual nerves, sensory nerves and hypoglossal nerve.

36. If performing surgical removal of the right submandibular gland on August 3, 2010, to make proper observations and properly identify the anatomy, landmarks and nerves during the procedure including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, sensory nerves and the hypoglossal nerve.

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37. To take proper precautions to identify, protect and not to injure the nerves for the face and tongue during the surgery on August 3, 2010 including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, sensory nerves and the hypoglossal nerve.

38. Not to utilize cautery, harmonic scalpels and other heat and thermal generating devises in the area of the nerves that supply the face and tongue including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, the sensory nerves and the hypoglossal nerve.

39. To utilize proper blunt dissection during surgery.

40. To utilize proper dissection during surgery.

41. To maintain an appropriate distance during the surgery from the nerves including, but not limited to, the marginal mandibular branch nerves, the lingual nerves, the sensory nerves and the hypoglossal nerves.

42. To properly monitor the nerves for the face and tongue during surgery including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, sensory nerves and the hypoglossal nerve.

43. Properly inspect the operative field and the nerves to determine whether they were injured or whether they were properly functioning.

44. To identify during the surgery on August 3, 2010, that he injured, stretched, kinked, bruised, cut, tore, crushed, compressed, transected, burned or otherwise impaired the nerves for the face and tongue and their functioning including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, the sensory nerves and the hypoglossal nerve.

45. To properly perform the surgery on August 3, 2010, in a manner not to injure the nerves for the face and tongue including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, sensory nerves and the hypoglossal nerve.

46. Not to remove excess tissue in removing the right submandibular gland on August 3, 2010.

47. To properly visualize, identify, isolate, retract and properly place clamps and properly use surgical instruments, cautery, retractors, scalpels and the harmonic scalpel during the surgery in a manner that would not cause injury, stretching, bruising, kinking, impairment, tearing, crushing, burning , cutting, compression,

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transection, burning or other damage to nerves for the face and tongue including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, sensory nerves and the hypoglossal nerve.

48. Not to utilize a harmonic scalpel during surgery or other instruments which generate heat and can cause thermal burns and not to use it in the area of the nerves including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, the sensory nerves and the hypoglossal nerve.

49. To properly diagnose the injury, bruising, stretching, kinking, compression, tearing, transection, burning, crush, and/or impairment to the nerves during surgery and to repair the injured nerves and surgically correct the damage.

50. To properly utilize a nerve stimulator or monitor during surgery and magnification.

51. To advise Patricia Merchand following the surgery that the nerves for the face and tongue including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, sensory nerves and the hypoglossal nerve were injured and/or damaged during surgery and that they required immediate evaluation and repair.

52. To make a referral following surgery for Patricia Merchand to a proper physician or institution so the damage to the nerves for the face and tongue which were injured during surgery could be evaluated and repaired.

53. To advise Patricia Merchand following the surgery and receipt of the pathology report that she did not have any submandibular stones, that Dr. Carpenter did not remove any submandibular stones and that there were no stones in her submandibular gland.

54. To properly timely diagnose and treat Patricia Merchand's infection following surgery by ordering appropriate antibiotics determined by cultures and sensitivity.

55. To obtain cultures following surgery to properly diagnose the infection, organism or other condition responsible for her incision breaking open and draining and to determine what the appropriate antibiotics were.

56. To prescribe proper antibiotics following surgery which the organisms were sensitive to.

57. To properly order tests including, but not limited to, laboratory and cultures to properly diagnose and treat Patricia Merchand's infection that developed following surgery.

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58. Not to repeatedly prescribe Keflex following the surgery when it was not effective and not a proper antibiotic or an effective antibiotic for the infection.

59. To advise Patricia Merchand following receipt of the pathology report that there were no stones of the submandibular gland and that none were removed during the surgery.

60. To properly assess Patricia Merchand's tongue and nerves following the surgery, identify the nerve damage and treat it and/or refer for assessment in treatment and repair of the damage.

## III. BREACH OF THE STANDARD OF CARE BY RICHARD CARPENTER, MD.

Dr. Carpenter breached the standard of care for physicians specializing in otolaryngology and board-certified in otolaryngology physicians and was negligent in 2010 with respect to Patricia Merchand in the following:

1. Failing to obtain a proper history and to accurately record the history.

2. Failing to perform a proper and accurate physical examination and record the findings.

3. Failing to formulate a proper differential diagnosis and diagnosis.

4. Failing to properly treat Patricia Merchand.

5. Failing to properly assess whether Patricia Merchand had an infection and the type of infection and to treat it with proper antibiotics and medications.

6. Failing to prescribe appropriate antibiotics and medications including, but not limited to, anti-staphylococcal, clindamyacin, NSAIDs.

7. Failing to accurately record the antibiotics prescribed and the number of antibiotic courses.

8. Failing to properly obtain and record Patricia Merchand's history of pain and duration of symptoms.

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9. Failing to properly record the treatment of Patricia Merchand and the prescriptions of antibiotics.

10. Failing to maintain accurate treatment records.

11. Failing to properly review the CT performed on June 30, 2010 and the radiologist's report of the CT.

12. Failing to properly note that the CT revealed mild right submandibular gland swelling without any evidence of stones or masses.

13. Charting that he removed multiple stones from Patricia Merchand in this office, when he had not removed any.

14. Charting that Patricia Merchand had been treated with multiple courses of antibiotics when he had only treated her with one prescription of Keflex.

15. Failing to advise and engage in a conservative treatment plan for Patricia Merchand which included watchful waiting.

16. Failing to advise Patricia Merchand of the available treatment options and recommend that conservative treatments available including, but not limited to, warm compresses, massages of the saliva gland and surrounding anatomy, manual manipulation/extraction of the stones of the submandibular gland and various items to stimulate the submandibular gland and saliva products such as lemon drops and performing surgery without instituting these treatments.

17. Performing surgery prior to treatment with anti-staphylococcal medications and antibiotics such as clindamycin.

18. Failing to re-evaluate and re-assess Patricia Merchand after the one stone of the submandibular gland was found and removed by Martin Tuck, D.D.S, to determine whether any further treatment was necessary.

19. Failing to postpone the surgery scheduled for August 3, 2010, after learning that Martin Tuck, D.D.S. found and removed one stone and to re-assess whether any further surgery or treatment was necessary.

20. Prematurely performing surgery on August 3, 2010, and negligently injuring the nerves to the face and tongue during the surgery.

21. Performing a surgical removal of the right submandibular gland on August 3, 2010, which was unnecessary.

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22. Failing to obtain adequate pre-operative informed consent including advising the patient of the risks of surgery, the likelihood of said risks and the alternatives to surgery.

23. Failing to assess Patricia Merchand for inflammation and/or infection.

24. Failing to obtain cultures and laboratory tests prior to performing surgery.

25. Failing to properly palpate the tongue, submandibular gland and surrounding anatomy prior to recommending or performing surgery.

26. Failing to attempt manual manipulation and/or squeezing in an attempt to remove the stone of the submandibular gland.

27. Failing to order and obtain an ultrasound and x-rays of the submandibular gland prior to performing surgery.

28. Failing to locate stones before surgery and, if unable to do so, not to schedule and perform surgery.

29. Scheduling or performing surgery when no stones could be identified.

30. Failing to drain the submandibular gland prior to recommending scheduling or performing surgery.

31. If a decision was made to proceed with a surgical procedure for the mild sialadenitis, failing to proceed with a different type of procedures, e.g., dilation of the duct, marsupialization of the duct, fine-needle aspiration, sialendoscopy and/or refer Patricia Merchand to a different physician or institution so these procedures could be performed.

32. Failing to properly perform the surgery on August 3, 2010 and to make a proper incision in a fashion that would not result in injury to the nerves for the face and tongue, including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, the sensory nerves and the hypoglossal nerve.

33. Failing to properly position Patricia Merchand and her head and neck during the surgery.

34. Failing to properly identify the correct location for the incision and to make all incisions in the proper location, plane and in a proper fashion.

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35. Failing to properly utilize the surgical instruments including, but not limited to, scalpels, retractors, cautery and clamps on August 3, 2010, in a manner that would not injure the nerves for the face and the tongue including, but not limited to, the marginal mandibular branch nerves, the lingual nerves, sensory nerves and hypoglossal nerve.

36. If performing surgical removal of the right submandibular gland on August 3, 2010, failing to make proper observations and properly identify the anatomy, landmarks and nerves during the procedure including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, sensory nerves and the hypoglossal nerve.

37. Failing to take proper precautions to identify, protect and not to injure the nerves for the face and tongue during the surgery on August 3, 2010 including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, sensory nerves and the hypoglossal nerve.

38. Utilizing cautery, harmonic scalpels and other heat and thermal generating devises in the area of the nerves that supply the face and tongue including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, the sensory nerves and the hypoglossal nerve.

39. Failing to utilize proper blunt dissection during surgery.

40. Failing to utilize proper dissection during surgery.

41. Failing to maintain an appropriate distance during the surgery from the nerves including, but not limited to, the marginal mandibular branch nerves, the lingual nerves, the sensory nerves and the hypoglossal nerves.

42. Failing to properly monitor the nerves for the face and tongue during surgery including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, sensory nerves and the hypoglossal nerve.

43. Failing to properly inspect the operative field and the nerves to determine whether they were injured or whether they were properly functioning.

44. Failing to identify during the surgery on August 3, 2010, that he injured, stretched, kinked, bruised, cut, tore, crushed, compressed, transected, burned or otherwise impaired the nerves for the face and tongue and their functioning including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, the sensory nerves and the hypoglossal nerve.

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45. Failing to properly perform the surgery on August 3, 2010, in a manner not to injure the nerves for the face and tongue including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, sensory nerves and the hypoglossal nerve.

46. Removing excess tissue in removing the right submandibular gland on August 3, 2010.

47. Failing to properly visualize, identify, isolate, retract and properly place clamps and properly use surgical instruments, cautery, retractors, scalpels and the harmonic scalpel during the surgery in a manner that would not cause injury, stretching, bruising, kinking, impairment, tearing, crushing, burning , cutting, compression, transection, burning or other damage to nerves for the face and tongue including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, sensory nerves and the hypoglossal nerve.

48. Utilizing a harmonic scalpel during surgery and other heat-generating instruments during surgery and using it in the area of the nerves including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, the sensory nerves and the hypoglossal nerve.

49. Failing to properly diagnose the injury, bruising, stretching, kinking, compression, tearing, transection, burning, crush, and/or impairment to the nerves during surgery and to repair the injured nerves and correct and repair the damage.

50. Failing to properly utilize a nerve stimulator or monitor during surgery and magnification.

51. Failing to advise Patricia Merchand following the surgery that the nerves for the face and tongue including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, sensory nerves and the hypoglossal nerve were injured and/or damaged during surgery and that they required immediate evaluation and repair.

52. Failing to make a referral following surgery for Patricia Merchand to a proper physician or institution so the damage to the nerves for the face and tongue which were injured during surgery could be evaluated and repaired.

53. Failing to advise Patricia Merchand following the surgery and receipt of the pathology report that she did not have any submandibular stones, that Dr. Carpenter did not remove any submandibular stones and that there were no stones in her submandibular gland.

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54. Failing to properly timely diagnose and treat Patricia Merchand's infection following surgery by ordering appropriate antibiotics determined by cultures and sensitivity.

55. Failing to obtain cultures following surgery to properly diagnose the infection, organism or other condition responsible for her incision breaking open and draining and to determine what the appropriate antibiotics were.

56. Failing to prescribe proper antibiotics following surgery which the organisms were sensitive.

57. Failing to properly order tests including, but not limited to, laboratory and cultures to properly diagnose and treat Patricia Merchand's infection that developed following surgery.

58. Repeatedly prescribing Keflex following the surgery when it was not effective and not a proper antibiotic or an effective antibiotic for the infection.

59. Failing to advise Patricia Merchand following receipt of the pathology report that there were no stones of the submandibular gland and that none were removed during the surgery.

60. Failing to assess and investigate following surgery, Patricia Merchand's complaints involving her tongue, to assess the tongue, the nerves, or to identify the nerve damage and to treat and correct it or refer her to another physician or institute for treatment and repair of the nerve damage. He should have ordered various tests to identify the problem described with the tongue including, but not limited to, CTs, MRIs, and nerve testing.

## IV. PROXIMATE CAUSE

The excision of the right submandibular gland surgery performed on August 3, 2010 was unnecessary surgery and should not have been performed. Patricia Merchand's condition did not warrant or justify surgery on August 3, 2010 to remove the submandibular gland. Prior to August 3, 2010, Patricia Merchand had one stone which had been removed by her dentist. Patricia Merchand did not have multiple stones. She did not require surgery on August 3, 2010 and she should not have had surgical removal of the submandibular gland on that date. If the

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surgery had not been performed and if it had not negligently been performed, she would not have sustained damage to her nerves for the face and tongue including, but not limited to, the submandibular branch nerves, the lingual nerve, the sensory nerves or the hypoglossal nerve.

The manner in which it is claimed that the negligence and breach of the standard of practice and care of Dr. Carpenter was the proximate cause of injury to Patricia Merchand is:

1. If he had properly treated Patricia Merchand in accordance with the standard of care, treated her conservatively, employed watchful waiting, prescribed anti-staphylococcal medications and antibiotics, e.g., clindamycin, prescribed NSAIDs, recommended warm compresses, massage and manual manipulation of the submandibular gland and/or a combination of these measures would have resolved the sialadenitis and Patricia Merchand would not have undergone submandibular gland surgery on August 3, 2010 and the nerves for her face and tongue including, but not limited to, the submandibular branch nerves, the lingual nerve, the sensory nerves or the hypoglossal nerve, would not have been injured during surgery.

2. If he had properly assessed and evaluated Patricia Merchand's condition, he would not have performed the surgical removal of the submandibular gland on August 3, 2010 and Patricia Merchand would not have received injury to the nerves for her face and tongue including, but not limited to, the submandibular branch nerves, the lingual nerve, the sensory nerves or the hypoglossal nerve, during surgery.

3. If he had performed a proper assessment and diagnosis he would not have performed the surgery on August 3, 2010 and he would not have injured the nerves for her face and tongue including, but not limited to, the submandibular branch nerves, the lingual nerve, the sensory nerves or the hypoglossal nerve, during surgery.

4. If he had accurately assessed Patricia Merchand's condition, including an assessment for infection and/or inflammation, properly ordered laboratory tests and cultures

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to assess her condition, including inflammation and/or infection, he would not have performed surgery on August 3, 2010, to remove the submandibular gland and the nerves for her face and tongue including, but not limited to, the submandibular branch nerves, the lingual nerve, the sensory nerves or the hypoglossal nerve, would not have been injured during surgery.

5. If he had properly reviewed the CT, and the radiologist's report for the CT, he would have learned that Patricia Merchant had mild sialadenitis, did not have stones of the submandibular gland and did not require surgery on August 3, 2010. If the unnecessary surgery had not been performed on August 3, 2010, Dr. Carpenter would not have injured during surgery the nerves for her face and tongue including, but not limited to, the submandibular branch nerves, the lingual nerve, the sensory nerves or the hypoglossal nerve, during surgery.

6. If he properly palpated and examined the tongue, submandibular gland and surrounding anatomy, he would have realized that Patricia Merchant did not have multiple stones of the submandibular gland and that she did not need surgery on August 3, 2010. If surgery had not been performed on August 3, 2010, he would not have injured the nerves for her face and tongue including, but not limited to, the submandibular branch nerves, the lingual nerve, the sensory nerves or the hypoglossal nerve.

7. If he performed and/or ordered an ultrasound and x-rays of the neck, head and submandibular gland, he would have realized that she did not have stones of the submandibular gland and that surgery to remove it was unnecessary and should not have been performed on August 3, 2010. If the surgery had not been performed on August 3, 2010, he would not have injured the nerves for her face and tongue including, but not limited to, the submandibular branch nerves, the lingual nerve, the sensory nerves or the hypoglossal nerve.

8. If Dr. Carpenter had properly advised Patricia Merchand that there were other safer and less invasive procedures such as dilation of the duct, drainage of the duct,

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marsupialization of the duct, fine-needle aspiration, sialendoscopy, Patricia Merchand would not have agreed to undergo the submandibular gland removal surgery on August 3, 2010, and the nerves for her face and tongue including, but not limited to, the submandibular branch nerves, the lingual nerve, the sensory nerves or the hypoglossal nerve, would not have been injured during the surgery on August 3, 2010.

9. If Dr. Carpenter referred Patricia Merchand to other specialists or medical institutions for treatment, Patricia Merchand's nerves for her face and tongue including, but not limited to, the submandibular branch nerves, the lingual nerve, the sensory nerves or the hypoglossal nerve, would not have been injured during the surgery performed on August 3, 2010.

10. If Dr. Carpenter had properly re-assessed and re-evaluated Patricia Merchand after Dr. Tuck manually manipulated the submandibular gland and extracted the stone, he would have realized that surgery to remove the submandibular gland should not have been performed on August 3, 2010 and, if the surgery had not been performed, Patricia Merchand's nerves for her face and tongue including, but not limited to, the submandibular branch nerves, the lingual nerve, the sensory nerves or the hypoglossal nerve, would not have been injured during the surgery.

11. If Dr. Carpenter had not performed the unnecessary surgery on August 3, 2010, to remove the submandibular gland, Patricia Merchand would not have sustained injury to the nerves for her face and tongue including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, sensory nerves and the hypoglossal nerve and her tongue.

12. If Dr. Carpenter advised Patricia Merchand about the surgery, that there were other viable treatment options, including anti-staphylococcal, clindamyacin, NSAIDs, watchful waiting, warm compresses, massages of the saliva gland and surrounding anatomy, manual manipulation/ extraction of the stones of the submandibular gland and various items to stimulate the submandibular gland and saliva products such as lemon drops, Patricia Merchand



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would not have agreed to undergo surgical removal of the submandibular gland on August 3, 2010 and the nerves of her face and tongue including, but not limited to, the submandibular branch nerves, the lingual nerve, the sensory nerves or the hypoglossal nerve, would not have been injured during surgery.

13. If he had properly manually manipulated the submandibular gland and/or squeezed it, he would have removed the stone that was later removed by Dr. Tuck, and realized that surgery to remove the submandibular gland was not necessary and should not have been performed on August 3, 2010. If surgery had not been performed on August 3, 2010, he would not have injured the nerves for her face and tongue including, but not limited to, the submandibular branch nerves, the lingual nerve, the sensory nerves or the hypoglossal nerve.

14. If Dr. Carpenter advised Patricia Merchand that the manner and method he planned to perform the surgical removal of the submandibular gland, and the manner and method he would perform it could result in permanent nerve damage to her tongue, Patricia Merchand would not have agreed to undergo surgical removal of her submandibular gland on August 3, 2010. If he properly advised her about the surgery, the risks and the alternative treatments, Patricia Merchand would not have agreed to the surgery.

15. If Dr. Carpenter had properly performed the surgery on August 3, 2010 and properly positioned Patricia Merchand for the surgery, made a correct incision, properly utilized the surgical instruments, retractors, scalpels and clamps, properly identified the anatomy, landmarks, and nerves, properly monitored and stimulated the nerves for her face and tongue during surgery including, but not limited to, the submandibular branch nerves, the lingual nerve, the sensory nerves or the hypoglossal nerve, properly performed the surgery in a manner not to injury the nerves, not to remove excess tissue, properly visualized, identified, isolated, retracted the nerves and structures and properly placed clamps, properly identified and corrected the injury , bruising, stretching, kinking, impairment, tearing, crushing, burning , cutting, compression, transection, burned or other

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damage, and/or impairment of the nerves for her face and tongue, he would not have injured the nerves of the face and tongue during surgery including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, sensory nerves and the hypoglossal nerve and her tongue or he would have corrected and repaired the damaged nerves.

16. If during surgery, he identified and monitored the nerves to the face and tongue, including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, sensory nerves and the hypoglossal nerve and her tongue, he would not have injured them.

17. If during the surgery he had properly monitored the nerves, assessed the nerves and used a nerve stimulator, he would not have injured the nerves and/or he would have detected the injury and corrected/repaired it or made arrangements for another physician to correct it.

18. If the nerves for the face and tongue including, but not limited to, the marginal mandibular branch nerves, the lingual nerve, sensory nerves and the hypoglossal nerve and her tongue, had not been injured during surgery on August 3, 2010, Patricia Merchand would not have sustained damage to her tongue, denervation of her tongue, multiple abnormalities of the tongue including paralysis, poor tongue protrusion, weakness and fasciculations of the tongue, disfigurement of the tongue, impairment of her ability to talk and eat and pain involving the tongue and other damage to her nerves and structures to her face and tongue.

19. When Patricia Merchand advised him following surgery of the problems relating to her tongue, if he had assessed the cause, e.g. examination, CTs, MRIs, nerve testing and diagnosed the nerve damage, it could have been repaired and surgically corrected. Due to his failure to timely diagnose and treat and/or arrange for treatment, too much time has elapsed and the nerve damage can no longer be repaired.

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## V. DAMAGES

As a proximate result of the negligence as set forth herein, and the injuries which were proximately caused by said negligence, Patricia Merchand has suffered, and continues to suffer, physical pain, physical suffering, disability, loss of speech, disfigurement of the tongue, loss of normal activities, loss of enjoyment of life, emotional, psychological and mental pain, trauma, suffering and injury.

As a proximate result of the negligence as set forth herein, and the injuries which were proximately caused by said negligence, Patricia Merchand has required, and will continue to require, hospitalization, surgery, medical testing, care and treatment, and has incurred, and will continue to incur, expenses for the medical care and treatment.

As a proximate result of the negligence as set forth herein, and the injuries which were proximately caused by said negligence, Patricia Merchand has been unable return to work and will be unable to return to work in the future.

As a proximate result of negligence in failing to advise Patricia Merchand that she did not have any stones removed during surgery and that there were no stones, she has and continues to experience shock, upset and emotional trauma.

As a proximate result of negligence as set forth herein, the injuries which were proximately caused by said negligence, Patricia Merchand has incurred, and will continue to incur economic losses including, but not limited to, loss of wages, loss of wage earning capacity and other economic expenses related to her inability to work.

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## VI. LIABILITY

At all times pertinent hereto, Richard Carpenter, M.D., was an employee, agent, servant and/or apparent and/or ostensible agent and/or agent by estoppel of Mid-Michigan Ear, Nose and Throat, P.C. Mid-Michigan Ear, Nose and Throat, P.C. is vicariously liable for the negligence of its employees, agents, servants, and/or apparent and/or ostensible agents and/or agents by estoppel, including Richard Carpenter, M.D., pursuant to *respondeat superior*.

Mid-Michigan Ear, Nose and Throat, P.C., as a corporation providing healthcare, owed a duty to its patients, including Patricia Merchand, to provide otolaryngology physicians competent to provide proper care and treatment. Richard Carpenter, M.D. was not competent to provide proper care and treatment. Mid-Michigan Ear, Nose and Throat, P.C. is liable for its own negligence in failing to do so, and is vicariously liable for the negligence of Richard Carpenter, M.D.

Richard Carpenter, M.D. is liable for his own negligence in failing to provide proper care and treatment for Patricia Merchand, as set forth herein.

At all times pertinent hereto, Mid-Michigan Ear, Nose and Throat, P.C., owed a duty to their/its patients, including Patricia Merchand, to properly supervise and direct Richard Carpenter, M.D., and is liable for its own negligence in failing to do so and is liable for the negligence of Richard Carpenter, M.D., pursuant to *respondeat superior*, agency and vicarious liability.

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## VII. DEMAND FOR MEDICAL RECORDS REQUESTED

Patricia Merchand requested that Dr. Carpenter and Mid-Michigan Ear, Nose and Throat, P.C., provide her with a complete copy of her records. However, they only produced an incomplete set of her records. Therefore, Patricia Merchand and her legal counsel once again request a complete set of Patricia Merchand's records.

## VIII. NOTICE

Names of health professionals, entities and facilities notified of a claim submitted agians them involving their care and treatment of Patricia Merchand include:

Richard Carpenter, M.D.

Mid-Michigan Ear, Nose and Throat, P.C.

To Those Receiving Notice: You should furnish this Notice to any person, entity or facility not specifically named herein that you reasonably believe might be encompassed in this claim.

If you believe you have received any other document which constitutes a notice of intent, pursuant to MCL 600.2912b, you are requested to advise the undersigned immediately. Otherwise, we will rely on your failure to respond to indicate that you have not received any other documents which you interpret as a notice of intent. We are relying on the date of service of this Notice of Intent to calculate the statutory tolling period of 182 days, as set forth in MCL 600.2912b, for filing the Complaint against Richard Carpenter, M.D. and Mid-Michigan Ear, Nose and Throat, P.C. If you believe any other dates are required to be used to calculate the 182-day notice period, you are requested to advise us immediately.

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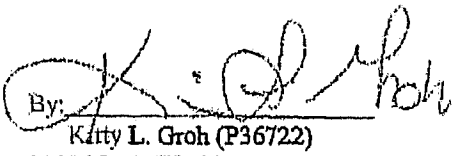
This Notice if prepared before filing of a Complaint and formal discovery. Information learned during discovery, including a complete copy of the medical records, depositions, may provide additional information concerning the events which occurred in May 2010, as it relates to the events involving Patricia Merchand.

Respectfully submitted,

FARHAT & STORY, P.C.
Attorneys for Claimant

By: 
Kitty L. Groh (P36722)
1003 North Washington Avenue
Lansing, Michigan 48906
(517) 351-3700

Dated: 7-9-12

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The undersigned certifies that she served a copy of the Notice of Intent to File a Claim and Lawsuit Pursuant to MCL 600.2912b, on behalf of Patricia Merchand on the following parties by way of certified mail, return receipt requested and regular mail on July 9, 2012.

Richard Carpenter, M.D.
6134 Graebear Trail
East Lansing, MI 48823

Richard Carpenter, M.D., Registered Agent
Mid-Michigan Ear, Nose and Throat, P.C.
1500 Abbott Road, Suite 400
East Lansing, MI 48823-1956

I declare under penalty of perjury that the foregoing statement is accurate and true to the best of my knowledge, information and belief.

Jyslime M. Sylvester

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# EXHIBIT P

2006 WL 1329156
Only the Westlaw citation
is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Court of Appeals of Michigan.

Valerie DUBE and Dennis Dube, Plaintiffs-Appellants,
v.
ST. JOHN HOSPITAL & MEDICAL CENTER, Defendant-Appellee.

Docket No. 265887.
|
May 16, 2006.

**Synopsis**

**Background:** Patient who was injured during gynecological procedure due to the alleged negligence of nurse brought medical malpractice action against hospital. The Wayne Circuit Court granted summary disposition to hospital on the basis of the statute of limitations. Patient appealed.

**Holdings:** The Court of Appeals held that:

[1] doctrine of res ipsa loquitur did not excuse patient from submitting expert affidavit;

[2] patient's attorney could not have reasonably believed that physician who submitted affidavit was qualified to testify as to nurse's negligence;

[3] fact that attorney did not have access to all of patient's medical records did not excuse his failure to file affidavit from qualified expert;

[4] fact that standards of care for generalists and specialists did not apply to nurses did not excuse failure to file affidavit of qualified expert;

[5] filing of complaint with defective affidavit did not toll the statute of limitations; and

[6] fact that hospital was the named defendant did not excuse patient from filing affidavit from professional with qualifications matching those of nurse.

Affirmed.

West Headnotes (6)

**[1] Health**
Affidavits of Merit or Meritorious Defense;Expert Affidavits
198H Health
198HV Malpractice, Negligence, or Breach of Duty
198HV(G) Actions and Proceedings
198Hk804 Affidavits of Merit or Meritorious Defense;Expert Affidavits
Doctrine of res ipsa loquitur did not excuse patient who sustained burns to her buttocks during cervical conization procedure from

submitting expert affidavit with her medical malpractice complaint against hospital; statute governing medical malpractice complaints required the filing of an affidavit of merit without exception, and record did not establish that patient's injury would not ordinarily occur in the absence of negligence, so as to make doctrine of res ipsa loquitur applicable. M.C.L.A. § 600.2912d(1).

Cases that cite this headnote

**[2] Health**

Affidavits of Merit or Meritorious Defense;Expert Affidavits

198H Health
198HV Malpractice, Negligence, or Breach of Duty
198HV(G) Actions and Proceedings
198Hk804 Affidavits of Merit or Meritorious Defense;Expert Affidavits

Patient's attorney could not have reasonably believed that board-certified physician specializing in obstetrics and gynecology was qualified to testify as to the negligence of circulating nurse who assisted in gynecological procedure performed on patient, and thus physician's affidavit did not satisfy the statutory requirement that a medical malpractice complaint be accompanied by an affidavit of merit, even though patient alleged the applicability of the doctrine of res judicata; statute requiring affidavit was clear in requiring the expert to have matching qualifications to the allegedly negligent professional. M.C.L.A. § 600.2169(1)(a, b, c), .2912d(1).

Cases that cite this headnote

**[3] Health**

Affidavits of Merit or Meritorious Defense;Expert Affidavits

198H Health
198HV Malpractice, Negligence, or Breach of Duty
198HV(G) Actions and Proceedings
198Hk804 Affidavits of Merit or Meritorious Defense;Expert Affidavits

Fact that patient's attorney did not have access to all of patient's medical records before filing medical malpractice suit arising out of a gynecological procedure did not excuse attorney from accompanying the complaint with an affidavit of merit from an expert qualified to testify as to the negligence of nurse who was later determined to have been responsible for the cautery plate that caused patient's injury; attorney did have intra-operative record before filing complaint, which identified nurse and her familiarity with the cautery plate. M.C.L.A. § 600.2169(1)(a, b, c), .2912d(1).

Cases that cite this headnote

**[4] Health**

Affidavits of Merit or Meritorious Defense;Expert Affidavits

198H Health
198HV Malpractice, Negligence, or Breach of Duty
198HV(G) Actions and Proceedings
198Hk804 Affidavits of Merit or Meritorious Defense;Expert Affidavits

Fact that neither the standard of care for generalists nor the standard of care for specialists applied to nurses did not excuse patient who brought medical malpractice action against hospital arising out of the alleged negligence of nurse from accompanying her complaint with affidavit of merit for an expert qualified to testify as to nurse's violation of the standard of care; statute defining an expert's qualifications to submit an affidavit of merit contained section applicable to health professionals in general, in addition to the sections for generalists and specialists. M.C.L.A. §§ 600.2169, .2912a.

Cases that cite this headnote

**[5] Health**

Affidavits of Merit or Meritorious Defense;Expert Affidavits

**Limitation of Actions**

Filing Pleadings

198H Health
198HV Malpractice, Negligence, or Breach of Duty
198HV(G) Actions and Proceedings
198Hk804 Affidavits of Merit or Meritorious Defense;Expert Affidavits
241 Limitation of Actions
241II Computation of Period of Limitation
241II(H) Commencement of Proceeding; Relation Back
241k117 Proceedings Constituting Commencement of Action
241k118 In General
241k118(2) Filing Pleadings

Patient's filing of medical malpractice complaint along with an affidavit of merit from a physician who patient's counsel could not have reasonably believed was qualified to testify as an expert against the nurse whose alleged negligence gave rise to the suit did not toll the statute of limitations applicable to patient's claim, and thus patient could not file a corrected affidavit after expiration of the statute of limitations; filing of complaint without the required affidavit was insufficient to commence the suit for limitations purposes. M.C.L.A. §§ 600.2169, .5856(a).

Cases that cite this headnote

**[6] Health**

Affidavits of Merit or Meritorious Defense;Expert Affidavits

198H Health
198HV Malpractice, Negligence, or Breach of Duty
198HV(G) Actions and Proceedings
198Hk804 Affidavits of Merit or Meritorious Defense;Expert Affidavits

Fact that hospital, rather than nurse, was the named defendant in patient's medical malpractice

action arising out of the alleged negligence of nurse did not excuse patient from filing affidavit of merit from professional with qualifications matching those of nurse; hospital was sued on vicarious liability theory, and affidavit of merit was required to address the agent for whom hospital was to be held responsible. M.C.L.A. § 600.2169.

Cases that cite this headnote

Wayne Circuit Court; LC No. 03-338048-NH.

Before: JANSEN, P.J., and NEFF and ZAHRA, JJ.

[UNPUBLISHED]

PER CURIAM.

***1** In this medical malpractice action brought against defendant St. John Hospital & Medical Center, plaintiffs appeal as of right from the trial court's order granting defendant summary disposition pursuant to MCR 2.116(C)(7). We affirm.

I

On March 25, 2002, Valerie Dube[1] underwent a cervical cold knife conization procedure performed by Dr. Michael F. Prysak, a licensed obstetrician and gynecologist, at St. John Hospital. During the conization procedure, a ground plate was attached to plaintiff. The ground plate was also attached to an electrocautery machine by way of a cord. The following day, plaintiff discovered that she had sustained burns on her bilateral buttocks. Plaintiff and her husband filed suit against Dr. Prysak[2] and defendant. They alleged that defendant, "by and through its employees" breached its duty to plaintiff by improperly placing the ground plate on her leg. Plaintiffs attached to their complaint an affidavit of merit signed by Dr. Lawrence Borow, a board-certified specialist in obstetrics and gynecology. Borow averred that, if the ground plate had been improperly placed on plaintiff at the time of surgery, there was a departure from the standard of care. However, subsequent discovery revealed that Daniella Dickens, the circulating nurse, was responsible for attaching the ground plate to plaintiff at the time of her surgery.

1 Because Dennis Dube's claims are derivative, the term "plaintiff" in the singular refers only to Valerie in this opinion.

2 After Dr. Prysak filed an affidavit of noninvolvement, plaintiffs dismissed him from the lawsuit.

Defendant moved for summary disposition pursuant to MCR 2.116(C)(7), (8), and (10). The trial court granted the motion pursuant to MCR 2.117(C)(7), holding that the affidavit of merit signed by Dr. Borow did not comply with MCL 600.2912d(1). Dr. Borow did not practice in the same specialty as Dickens, and therefore, pursuant to MCL 600.2169, he was not qualified to testify as an expert witness against

Dickens. Further, because the affidavit of merit did not comply with MCL 600.2912d, the statute of limitations was not tolled when the complaint was filed and, thus, plaintiff's claims were barred by the statute of limitations.

II

This Court reviews de novo a trial court's decision on a motion for summary disposition. *Smith v. Globe Life Ins. Co.*, 460 Mich. 446, 454, 597 N.W.2d 28 (1999). Summary disposition is proper under MCR 2.116(C)(7) if "[t]he claim is barred because of ... statute of limitations." In reviewing a trial court's decision under MCR 2.116(C)(7), this Court "consider[s] all documentary evidence submitted by the parties, accepting as true the contents of the complaint unless affidavits or other appropriate documents specifically contradict it." *Bryant v. Oakpointe Villa Nursing Centre, Inc,* 471 Mich. 411, 419, 684 N.W.2d 864 (2004).

The interpretation of a statute is a question of law, reviewed de novo. *Eggleston v. Bio-Med Applications of Detroit, Inc.*, 468 Mich. 29, 32, 658 N.W.2d 139 (2003). Additionally, we review de novo the issue whether summary disposition was properly granted with prejudice. *Rinke v. Automotive Moulding Co.*, 226 Mich.App. 432, 439, 573 N.W.2d 344 (1997).

***2** On appeal, plaintiff raises numerous issues that were not raised before or decided by the trial court, which we generally decline to review. *Polkton Charter Twp. v. Pellegrom,* 265 Mich.App. 88, 95, 693 N.W.2d 170 (2005). However, if the issue involves a question of law and all the facts necessary for its resolution have been presented, we may decide the issue. *Aetna Cas. & Surety Co. v. American Community Mut. Ins. Co.*, 199 Mich.App. 30, 34, 501 N.W.2d 174 (1992).

III

**[1]** Plaintiff first claims that the trial court erred in granting summary disposition to defendant because expert testimony is not required in a medical malpractice action that relies on the doctrine of res ipsa loquitur. We disagree.

In a medical malpractice action, if a plaintiff is unable to prove the actual occurrence of a negligent act, the doctrine of res ipsa loquitur entitles the plaintiff to an inference of negligence if the following four elements are met:

> "(1) the event must be of a kind which ordinarily does not occur in the absence of someone's negligence;
>
> (2) it must be caused by an agency or instrumentality within the exclusive control of the defendant;
>
> (3) it must not have been due to any voluntary action or contribution on the part of the plaintiff"; and
>
> (4) "[e]vidence of the true explanation of the event must be more readily accessible to the defendant than to the

> plaintiff." [*Woodard v. Custer,* 473 Mich. 1, 7, 702 N.W.2d 522 (2005), quoting *Jones v. Porretta,* 428 Mich. 132, 150-151, 405 N.W.2d 863 (1987).]

The first element is not only the most crucial element, but it is also the element most difficult to establish. *Locke v. Pachtman,* 446 Mich. 216, 230-231, 521 N.W.2d 786 (1994). The fact of a bad medical result itself is insufficient to satisfy the first element. *Id.* at 231, 521 N.W.2d 786. Therefore, "the fact that the injury complained of does not ordinarily occur in the absence of negligence must either be supported by expert testimony or must be within the common understanding of the jury." *Id.*

While we accept and agree that the doctrine of res ipsa loquitur can apply in a medical malpractice action, we do not agree with plaintiff's assertion that, because expert testimony is not always necessary in a case based on the doctrine of res ipsa loquitur, an affidavit of merit was unnecessary in this case. Plaintiff argues that, because it would be within the common understanding of the jury that plaintiff would not have received the burns on her buttocks absent negligence, the case could proceed without an expert affidavit. In a medical malpractice action, however, it is clear that the plaintiff or the plaintiff's attorney *"shall* file with the complaint an affidavit of merit signed by a health professional." MCL 600.2912d(1) (emphasis added). The purpose of the affidavit of merit "is to deter frivolous medical malpractice claims." *Young v. Sellers,* 254 Mich.App. 447, 452, 657 N.W.2d 555 (2002). " 'The substance of the affidavit, in essence, is a qualified health professional's opinion that the plaintiff has a valid malpractice claim." ' *Scarsella v. Pollak,* 461 Mich. 547, 548, 607 N.W.2d 711 (2000) (quoting this Court's earlier opinion). The Legislature's use of the word "shall" in MCL 600.2912d(1) " 'indicates that an affidavit accompanying the complaint is mandatory and imperative." ' *Scarsella, supra* at 549, 607 N.W.2d 711. If the plain and ordinary meaning of a statute's language is clear, judicial construction is neither necessary nor permitted. *Nastal v. Henderson & Assoc. Investigations, Inc.,* 471 Mich. 712, 720, 691 N.W.2d 1 (2005).

***3** Moreover, we note that, based on the record, this case is not one in which the doctrine of res ipsa loquitur applies. The record does not support a conclusion that plaintiff's injuries would not have occurred but for negligence of defendant's agents. Indeed, plaintiff's own expert suggested that an equipment failure could cause the burns, and it does not appear that a jury would have a common understanding of how plaintiff sustained injury. Moreover, the record does not reveal whether the injury was a possible complication. And there has been no showing that evidence of the true explanation of plaintiff's injury was more readily accessible to defendant than plaintiff. Plaintiff's argument relying on res ipsa loquitur is misplaced.

## IV

Plaintiff next argues that, even if an affidavit of merit is required in a medical malpractice action based on the doctrine of res ipsa

loquitur, her attorney's belief that Dr. Borow was qualified to sign the affidavit of merit averring to the negligence of Dickens was reasonable. We disagree.

A

According to MCL 600.2912d(1), the necessary affidavit of merit in a medical malpractice case shall be signed "by a health professional who the plaintiff's attorney reasonably believes meets the requirements for an expert witness under section 2169." MCL 600 .2169 contains three requirements for an expert witness: (1) if the alleged negligent professional is a specialist, the expert witness must specialize in the same specialty on the date of the alleged malpractice, and if the alleged negligent professional is a specialist who is board certified, the expert witness must also be board certified in the same specialty, MCL 600.2169(1)(a); (2) the expert witness, in the year preceding the date of the alleged malpractice, must have devoted a majority of his or her professional time to either or both of the active clinical practice of the same health profession or specialty practiced by the alleged negligent professional or the instruction of students in the same health profession or specialty practiced by the alleged negligent professional, MCL 600.2169(1)(b); and (3) if the alleged negligent professional is a general practitioner, the expert witness must have devoted a majority of his or her professional time in the year preceding the date of the alleged malpractice to active clinical practice as a general practitioner or the instruction of students in the same health profession in which the alleged negligent professional is licensed, MCL 600.2169(1)(c). Stated summarily, the qualifications of the expert witness must "match" the qualifications of the alleged negligent health professional. *Decker v. Flood,* 248 Mich.App. 75, 85, 638 N.W.2d 163 (2001).

However, because the affidavit of merit must be filed before discovery has commenced, the plaintiff's attorney must only reasonably believe that the affiant is qualified to sign the affidavit of merit. *Grossman v. Brown,* 470 Mich. 593, 599, 685 N.W.2d 198 (2004). Whether an attorney's belief is reasonable depends on "the circumstances." *Geralds v. Munson Healthcare,* 259 Mich.App. 225, 233, 673 N.W.2d 792 (2003); *Watts v. Canady,* 253 Mich.App. 468, 471, 655 N.W.2d 784 (2002). Relevant circumstances include the information available to and the investigation conducted by the plaintiff's attorney. See *Grossman, supra* at 599-600, 685 N.W.2d 198; *Geralds, supra* at 233, 673 N.W.2d 792.

*4 **[2]** In this case, plaintiff argues that her attorney's belief, that Dr. Borow was an appropriate expert to sign the affidavit of merit, was reasonable because there is no case law delineating the appropriate health professional required to sign an affidavit of merit in a case based on the doctrine of res ipsa loquitur. However, absent case law addressing the specific issue phrased by plaintiff, we find that her attorney could not reasonably believe that the plain language of MCL 600.2912d would apply differently in an action relying on res ipsa loquitur.

The language of MCL 600.2129d is clear: the plaintiff's attorney "shall file with the complaint an affidavit of merit signed by a health professional who the plaintiff's attorney reasonably believes meets the requirements for an expert witness" under MCL 600.2169. Thus, plaintiff's counsel must have known that an affidavit filed by the potential, necessary expert was required.

B

Plaintiff also argues that her attorney could have reasonably believed that Dr. Borow was the appropriate health professional to sign the affidavit based on a footnote in *Cox v. Flint Bd. of Hosp. Managers,* 467 Mich. 1, 651 N.W.2d 356 (2002). In *Cox,* the trial court instructed the jury that the defendant hospital could be held vicariously liable if it found that the "neonatal intensive care unit" was negligent. *Id.* at 10, 651 N.W.2d 356. The Supreme Court reversed, holding that the trial court's "unit" instruction was error because it failed to specify which agents were alleged to have been negligent, and it failed to ensure that the jury understood the applicable standard of care with respect to each agent. *Id.* at 14-15, 651 N.W.2d 356. In a footnote, the Supreme Court noted that "plaintiffs did not argue at trial that the res ipsa loquitur doctrine applied." *Cox, supra* at 14 n. 14, 651 N.W.2d 356. Plaintiff contends that this reference supports her attorney's reasonable belief that, because he was relying on res ipsa loquitur, he need not file an affidavit of merit averring to the negligence of Dickens since proof of Dickens' individual negligence was unnecessary to prevail in this case. We disagree. The issues in *Cox* did not involve the requirements of an affidavit of merit in a case based on res ipsa loquitur.

C

**[3]** Finally, plaintiff contends that her attorney's belief that Dr. Borow was an appropriate expert to sign the affidavit of merit was reasonable because, at the time the complaint was filed, he did not have access to all plaintiff's medical records. However, the medical records provided to plaintiff pre-suit included the intra-operative record, which contained a list of all those involved in plaintiff's conization procedure. This list identified Dickens and her familiarity with the cautery plate used during the surgery. Accordingly, while plaintiff and her attorney may not have known who placed the ground plate on plaintiff, they had knowledge of all the persons whose actions may have contributed to the burns plaintiff received. Plaintiff's attorney could have filed an affidavit of merit related to the nursing care and signed by a nurse who qualified to testify as an expert witness against Dickens.

***5** We cannot conclude that plaintiff's attorney reasonably believed that Dr. Borow was a proper affiant to aver to the negligence of anyone involved in plaintiff's surgery, other than Dr. Prysak, including Dickens.

V

**[4]** Plaintiff next claims that she was not required to file an affidavit of merit with respect to her claims based on Dickens' conduct.

MCL 600.2912a articulates the standards of care that are applicable to general practitioners and specialists. Because both general practitioners and specialists engage in the practice of medicine and nurses do not, the Supreme Court has held that nurses are neither general practitioners nor specialists. *Cox, supra* at 19-20, 651 N.W.2d 356. Accordingly, the Supreme Court has concluded that the standards of care for general practitioners and specialists, as articulated in MCL 600.2912a, do not apply to nurses. *Id.* at 20, 651 N.W.2d 356. Plaintiff reasons that based on the ruling in *Cox,* the requirements of MCL 600.2169 also cannot be applied to nurses. We disagree. If we apply the definitions of the terms "general practitioner" and "specialist," as provided in *Cox, supra,* related to MCL 600.2912a, to the language of MCL 600.2169, plaintiff's argument fails as a matter of law.

MCL 600.2169 contains three criteria that must be met before a health professional may give expert testimony on the appropriate standard of care. The criteria are set forth in subsections (a), (b), and (c) of MCL 600.2169(1). Subsection (a) applies only to specialists, while subsection (c) applies only to general practitioners. However, subsection (b) is not limited to general practitioners or specialists. It applies to health professionals in general. Pursuant to MCL 600.2169(1)(b)(i), during the year immediately preceding the date of the alleged malpractice, the expert must have devoted a majority of his professional time to the active clinical practice of the same health profession as the alleged negligent professional. Alternatively, pursuant to MCL 600.2169(1)(b)(ii), an affiant can qualify as an expert witness if, during the same time frame, he or she instructed students in an accredited health professional school and in the same health profession in which the alleged negligent professional is licensed. MCL 600.2169 is not limited to physicians, but it applies to all health professionals. We are required to enforce plain and unambiguous statutory language as written. *Nastal, supra* at 720, 691 N.W.2d 1. Therefore, we reject plaintiff's argument that an expert affidavit, meeting the requirements of MCL 600.2169, was unnecessary in this medical malpractice action based on the conduct of a nurse.

Dr. Borow failed to satisfy the statutory requirements of MCL 600 .2169(1)(b), with respect to Dickens' negligence. As such, the affidavit of merit filed by plaintiff with her complaint was insufficient.

## VI

**[5]** Plaintiff next argues that the trial court erred in dismissing her claim with prejudice because the complaint was actually accompanied by an affidavit of merit. Thus, the statute of limitations was tolled when the complaint was filed, and she is entitled to file the correct affidavit. We disagree.

***6** MCL 600.5856(a) provides that the statute of limitations is tolled "[a]t the time the complaint is filed, if a copy of the summons and complaint are served on the defendant" within the applicable time limit. However, because the Legislature's requirement that an affidavit of merit be filed with the complaint is " 'mandatory and imperative,' " the Supreme Court has ruled that " 'for statute of limitations purposes in a medical malpractice case, the mere tendering of a complaint without the required affidavit of merit is insufficient to commence the lawsuit.' " *Scarsella, supra* at 549, 607 N.W.2d 711. In announcing this rule, the Supreme Court noted that it was only addressing "the situation in which a medical malpractice plaintiff wholly omits to file the affidavit [of merit]...." *Id.* at 553, 607 N.W.2d 711. The Supreme Court further noted that this rule "does not extend to a situation in which a court subsequently determines that a timely filed affidavit is inadequate or defective." *Id.* The Supreme Court left open the issue whether a grossly nonconforming affidavit could suffice to toll the statute of limitations. *Id.* at 553 n. 7, 607 N.W.2d 711. This Court subsequently determined the statute of limitations in a medical malpractice action was not tolled when the plaintiff filed an affidavit of merit signed by a health professional whom the plaintiff's attorney could not have reasonably believed qualified to testify as an expert witness against the alleged negligent physician. *Geralds, supra* at 233, 235, 673 N.W.2d 792. This Court explained:

> Semantics aside, whether the adjective used is "defective" or "grossly nonconforming" or "inadequate," in the case at bar, plaintiff's affidavit did not meet the standards contained in MCL 600.2912d(1) and failed to meet the express language of MCL 600.2169(1) because the affiant was a doctor with a different board certification than third-party defendant's board certification. [*Id.* at 240, 673 N.W.2d 792.]

More recently, this Court addressed the issue in *Kirkaldy v. Rim (On Remand),* 266 Mich.App. 626, 702 N.W.2d 686 (2005). The defendants in that case were board-certified neurologists, but the plaintiff's affidavit of merit was signed by a board-certified neurosurgeon. *Id.* at 628, 702 N.W.2d 686. This Court had previously held that the plaintiff's attorney could not have reasonably believed that the neurosurgeon qualified as an expert witness to testify against the defendants. See *Kirkaldy v. Rim,* 251 Mich.App. 570, 577-579, 651 N.W.2d 80 (2002), vacated in part 471 Mich. 924 (2004). On remand, this Court held that it did not need to determine if the affidavit was merely nonconforming or was grossly nonconforming because *Geralds, supra* dictated that the defective affidavit did not toll the statute of limitations, and dismissal with prejudice was the appropriate result. *Kirkaldy (On Remand), supra* at 635-637.

We are bound by the published decisions of this Court, MCR 7.215(C)(2), and thus, because plaintiff's affidavit of merit did not comply with MCL 600.2912d, the statute of limitations was not tolled when plaintiff filed her complaint. Therefore, the period of limitations expired, and the trial court properly dismissed the instant case with prejudice.

VII

*7 **[6]** Plaintiff next claims that she was not required to file an affidavit of merit by a nurse because Dickens is not a party to the lawsuit. This argument has previously been rejected by this Court. In *Nippa v. Botsford Gen. Hosp. (On Remand)*, 257 Mich.App. 387, 392-393, 668 N.W.2d 628 (2003), this Court held that, when a plaintiff in a medical malpractice action is suing an institutional defendant under a vicarious liability theory, the plaintiff must still file an affidavit of merit from a health professional whose credentials match those of the institutional defendant's agent involved in the alleged malpractice. Accordingly, plaintiff was required to file an affidavit of merit signed by a nurse even though Dickens is not a party to the lawsuit. St. John Hospital, the institutional defendant, was sued on a vicarious liability theory.

VIII

Finally, plaintiff claims that the Supreme Court in *Scarsella, supra* at 549, 607 N.W.2d 711, ignored the plain language of MCL 600.5856 in holding that a medical malpractice complaint filed without an affidavit of merit does not toll the statute of limitations. We are bound by Supreme Court precedent, *Boyd v. W G Wade Shows,* 443 Mich. 515, 523, 505 N.W.2d 544 (1993), and will not review whether our Supreme Court ignored the plain language of MCL 600.5856 when deciding *Scarsella, supra.*

Affirmed.

**All Citations**

Not Reported in N.W.2d, 2006 WL 1329156

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# EXHIBIT Q

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF INGHAM

PATRICIA MERCHAND,

Plaintiff,

vs.

File No. 12-1343-NH

RICHARD L. CARPENTER MD, and MID-MICHIGAN EAR, NOSE AND THROAT PC, a Michigan professional service corporation,

Hon. Rosemarie E. Aquilina

Defendants.

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**ORDER GRANTING DEFENDANT'S MOTION TO STIKE IRRELEVANT EXPERT STANDARD OF CARE CRITICISMS ON UNPLED CLAIMS**

At a session of said Court held in Ingham County Circuit Court, Lansing, Michigan, on this 19th day of March, 2015.

PRESENT: Hon. Rosemarie E. Aquilina
Circuit Court Judge

This matter having come before the Court on Defendant's Motion to Strike Irrelevant Standard of Care Criticisms of Plaintiff's Experts, a brief having been filed in support of same, oral arguments held in open Court, and the Court being otherwise fully advised in the premises,

IT IS HEREBY ORDERED AND ADJUDGED that Plaintiff's claims and her expert's Standard of Care claims + testimony are limited to what has been pled in the Complaint, more specifically whether Dr. Carpenter acted with the standard care when he performed the August 3, 2010 right submandibular gland removal surgery.

It is so Ordered.

Rosemarie E Aquilina
Hon. Rosemarie E. Aquilina
Circuit Court Judge
P37670

Attest: A True Copy

_____
Deputy Clerk